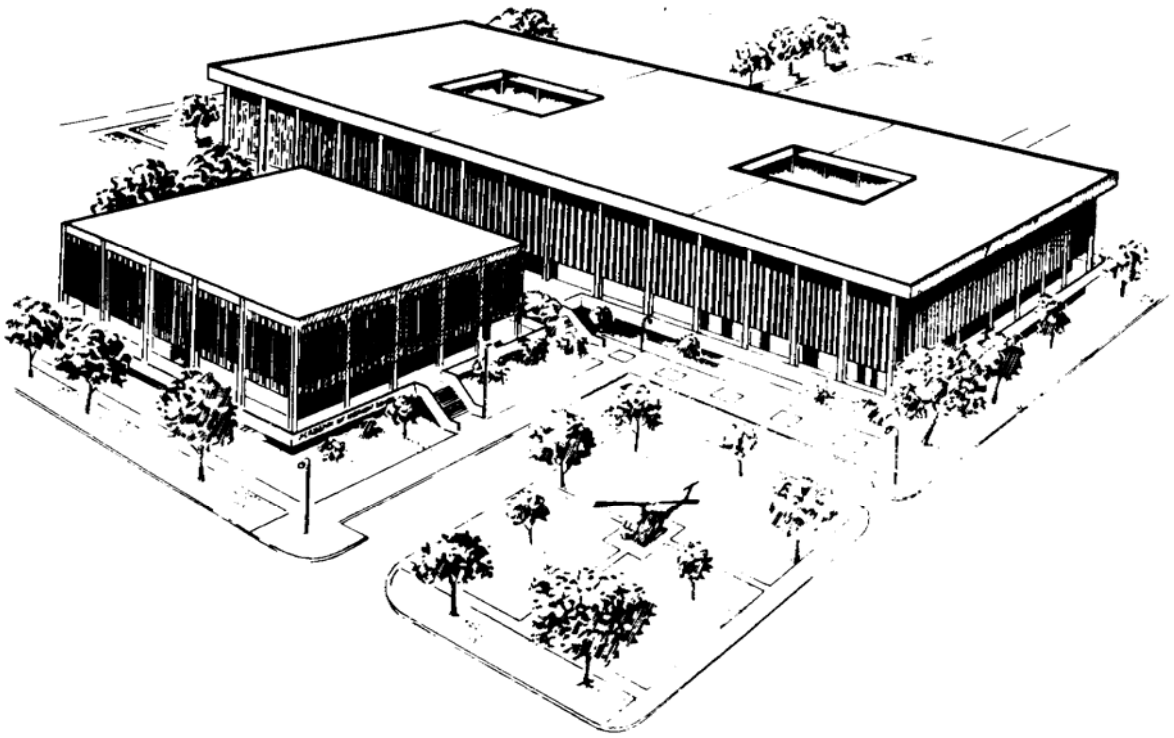
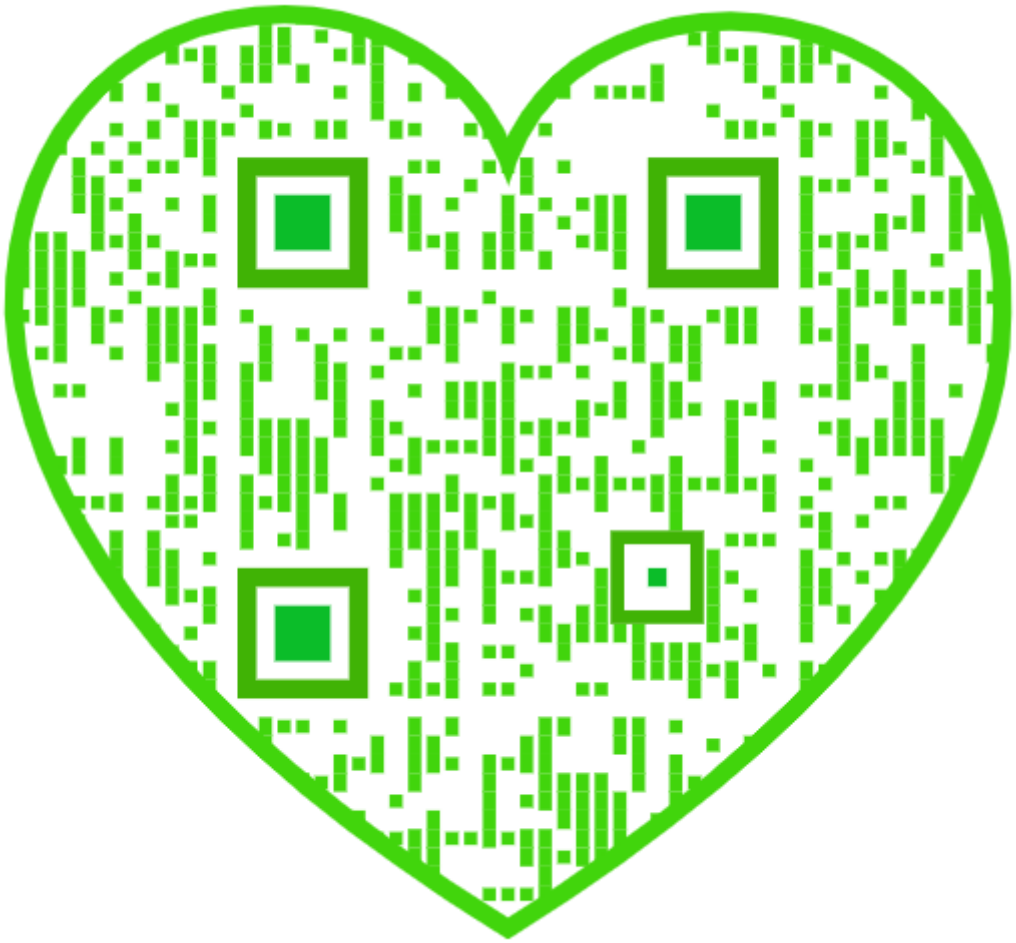
U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
FORT SAM HOUSTON, TEXAS 78234-6100



HEALTH CARE ETHICS II

SUBCOURSE MD0067 EDITION 200



LESSON ASSIGNMENT

LESSON 1	Patient Consent.
TEXT ASSIGNMENT	Paragraphs 1-1 through to 1-26.
LESSON OBJECTIVES	Upon completion of this lesson, you should be able to:

1-1. Identify types of consent: implied, express, and informed.

1-2. Identify advantages of written express consent over oral express consent.

1-3. Identify situations in which written consent to medical treatment is required.

1-4. Identify situations in which consent is not required to treat a service member on active duty.

1-5. Identify other exceptions to the consent requirement.

1-6. Identify situations in which substitute consent must be obtained from persons other than the patient.

1-7. Identify five elements of informed consent.

1-8. Identify elements of disclosure and exceptions to disclosure

1-9. Identify conditions for applying therapeutic privilege.

1-10. Identify the definitions of a mature minor and an emancipated minor.

1-11. Identify consent for mature and emancipated minors.

1-12. Identify situations in which the extension doctrine of consent may be appropriately applied.

SUGGESTION While completing the assignment, complete the exercises at the end of each section. These exercises will help you to achieve the lesson objectives.

LESSON 1

PATIENT CONSENT

Section I: PATIENT CONSENT AND DISCLOSURE

1-1. INTRODUCTION

a. **The Patient's Right to Know the Potential Risks and Benefits.** Principle 13 of the Patient's Bill of Rights (see Appendix) covers the concept of patient consent: "The patient has a legal right to refuse any particular drug, test, procedure, or treatment." Today, more than ever, with the many new, complex, and relatively untried diagnostic and therapeutic procedures available, it is important to make certain that patients give their consent to procedures with an understanding of the risks and benefits. It is not just the complex procedures that pose risks. Even simple procedures can present problems. Infection may be introduced by a needle; sudden death may follow the intravenous administration of such relatively inert substances as dehydrochloric acid. No agent that can modify the internal environment of the body can be used without hazard. Entry by needles or other instruments into tissues, vessels, or cavities of the body involves risk of infection.

b. **Medical Malpractice Lawsuits.** Patient consent is an area in which the potential for legal liability is great. Acquainting yourself with consent requirements will minimize the Army's risk of liability.

c. **Lesson Scope**. This lesson covers the various types of consent, the requirements for informed consent, standards of disclosure, exceptions to disclosure, and the decision-making role of patients and their representatives.

MEDICAL MALPRACTICE

The frequency of medical malpractice claims in the United States (US) (number of claims per 100 physicians) rose at an average of ten percent a year between 1975 and 1985, reaching a level of 0.163 percent by 1986. Frequency varied widely by specialty and state. Claims against obstetricians and other high-risk surgical specialties were two to three times the average for all specialties. Among six states surveyed by the General Accounting Office, claim frequency per 100 physicians ranged from 8.6 in Arkansas to 35.7 in New York. By 1986, the typical payment was about $20,000. But, 50 percent of the dollars paid were on five percent of all claims, reflecting the minority of cases involving permanent disability or death for which the awards are larger. Malpractice insurance costs have risen commensurately. Costs in Canada and the U.K. where legal systems tend to favor potential plaintiffs less than our system have increased just as dramatically.[1]

1-2. INFORMED CONSENT

a. **Consent, a Free and Rational Act**. The ethical basis for consent is respect for persons, their right to autonomy (self-determination), and the protection of those with a diminished capacity for protecting their own interests, that is, children and incompetent adults. Legal doctrine defines consent as indicated below.

> **Consent:** the free (uncoerced) authorization of the patient to make his or her own decisions as to whether or not, and how to receive competent medical care.

ETHICAL BASIS OF CONSENT

- Respect for a person's principle.
- Autonomy (self-determination) principle.
- Protection of those with diminished.
- autonomy (children, incompetent adults).

LEGAL APPLICATION

- Voluntary, informed consent from a patient or an authorized patient representative.

Figure 1-1. The legal right to informed consent has an ethical basis.

b. **Consent Based on Substantial Knowledge.** The law requires that the patient or patient's representative be given sufficient information concerning available choices so that the consent is an *informed* consent.

> **Informed consent:** the free (uncoerced) authorization of a procedure that is given by a competent individual, having sufficient information.

In most circumstances, authorization is secured from the patient or the patient's representative who gives express or implied consent. If the patient or patient's representative decides not to consent, the examination or procedure usually cannot be performed. However, in several circumstances, the law overrides the decision and provides authorization for involuntary treatment, such as civil commitment for treatment of certain mental illnesses and substance abuse.

1-3. CONSENT REQUIREMENTS

a. **Obtaining Consent and Informing the Patient**. The legal requirement to obtain informed consent imposes two duties on the physician: the duty to obtain consent and the duty to inform. Though related, a trisection in either of these two areas (failure to obtain consent or failure to inform) constitutes distinct and separate torts.

b. **Failure to Obtain Consent (Battery).** The first medical consent lawsuits came about when surgery was done without consent. In *Schloendorff vs. Society of New York Hospital* (ICY, 1914), the patient successfully sued for battery because the physician proceeded with surgery when the patient had only agreed to an exploratory exam (an ether exam to determine the nature of a fibroid tumor). Justice Cardozo's oft-quoted statement from that case is considered the root premise of consent law. Tort law on assault and battery can be considered the foundation for the consent requirement in the field of health care. Even a routine x-ray procedure is covered under tort law. Medical and surgical procedures that involve touching the patient's person, including the simplest manipulation of a limb, must be properly authorized. Otherwise, the person performing the procedure may be subject to legal action for battery.

- Obtaining the patient's consent. ➔➔➔➔➔➔ Bars legal action for battery.
- Informing the patient➔➔➔➔➔➔ Bars negligence for failure to inform.

Figure 1-2. Informing the patient and obtaining consent are related, but legally separate duties.

SURGEON LIABLE FOR PROCEEDING WITH SURGERY WHEN CONSENT WAS ONLY FOR AN EXPLORATORY EXAM

In *Pugsley vs. Privette* (Va., 7980), Mrs. Privette, a private patient of the hospital's chief of surgery, *requested* that the surgeon be present when she underwent an exploratory laparotomy by her gynecologist. The chief of surgery agreed, but could not be found when Mrs. Privette arrived at the operating room. The patient then indicated that she did not want to continue under those circumstances. The gynecologist proceeded anyway, and during the operation nicked the patient's ureter. She sued the gynecologist. The court ruled that the gynecologist was liable for battery because he had proceeded with the operation when Mrs. Privette had, in effect, revoked her consent. The court said, "It is immaterial to the issue of battery that the jury found that the operation was not negligently performed. And it avails little to argue now that no good purpose would have been served by the chief of surgery's presence. It was Mrs. Privette's body on which the operation was to be performed, and the decision was one peculiarly for her to make."

PLASTIC SURGEON WHO DOES MORE THAN THE PATIENT ASKED FOR IS LIABLE

In *Meretsy vs. Ellenby* (Fla., 1979), the patient asked the plastic surgeon to remove a bump on the bridge of her nose, but specifically directed that nothing be done to the tip of her nose. When the physician ignored her express directions and altered the tip of her nose, she successfully sued for battery.

c. **Failure to Inform (Negligence).** Later medical consent lawsuits involved physicians who had obtained consent, but had not given the patient sufficient information to make an informed decision. Failure to inform is a form of negligence.

FAILURE TO INFORM ABOUT RISKS OF NOT TREATING

In *Truman vs. Thomas* (Calif., 1980), the patient had been under the care of the physician (a general practitioner) for several years. The physician was found negligent for failing to inform the patient of the risks of not consenting to a recommended Papanicolaou's test (Pap test). Had the Pap test been performed, the patient's cervical cancer could have been discovered in time to begin treatment and extend her life.

1-4. THE PHYSICIAN OBTAINS CONSENT

It is primarily the physician's responsibility to advise the patient and to obtain consent. It is poor practice to leave completion of the consent form to the nurse, as is sometimes done. The form should be completed when the physician has made his or her explanation and is satisfied that the patient truly understands and consents. When informed consent cannot be obtained, the hospital gets involved in advising members of the medical staff on how to secure authorization.

1-5. NATURE OF CONSENT

a. **Providing Substantial Information.** Consent is a free and rational act, which presupposes knowledge of the nature of the procedure to which consent is given. That knowledge does not have to be exact in all of its details, but it does have to be substantially correct. The patient's consent is not free and rational if it is based on ignorance of the essential nature and consequences of a treatment or operation.

b. **Obstacles to Providing Substantially Correct Information.** Providing the necessary information to a patient may pose unique problems to the health care provider. Sometimes the treatment is so complex that it is difficult to give the patient a correct understanding of the nature of treatment. In other cases, the patient might prefer not to know certain unpleasant things, for example, the uncomfortable sensations experienced during a barium enema. In still other instances, an explanation might feed irrational fears, creating resistance and difficulty for health care providers in administering the treatment. Some patients suffering from denial are unable to comprehend, process, or remember information about their illness or its recommended treatment. Such patients don’t want to believe they have a serious illness, and can’t accept their diagnosis and/or prognosis. Some are so beset by fears and anxiety that they listen without hearing or hear without understanding. And some patients refuse to listen, abandoning their decision-making role entirety.

1-6. IMPLIED CONSENT

a. **Inferred (From Patient Conduct).** When a patient voluntarily submits to a procedure with apparent knowledge of the nature of said procedure, the courts will usually find implied consent.

> **Implied consent**: approval inferred from the patient's conduct; or voluntary submission with apparent knowledge of the nature of the procedure; or presumed consent in a life-threatening emergency.

It may be taken for granted that a patient who requests admission to a hospital, or seeks a clinical appointment or other treatment, implicitly consents to the ordinary, diagnostic and therapeutic measures used by the physician and hospital. The very request for a diagnosis and cure suggests a willingness to submit to many procedures. Therefore, it is not necessary to explain each of these ordinary measures to obtain consent. In implied consent situations, the patient's actions or other circumstances indicate consent.

IMPLIED CONSENT SITUATIONS

Consent Inferred:

- Request for admission to a hospital.
- Presentation for a clinical appointment.

Consent Presumed:

- Emergency situations (with an imminent threat to life, health, or well-being).

Figure 1-3. In implied consent situations, the patient's actions or other circumstances indicate that consent exists.

b. **Voluntary Submission with Apparent Knowledge.** If a patient voluntarily submits to a procedure with actual or apparent knowledge of what is about to transpire, this submission constitutes implied consent. It is not practical, nor necessary for an x-ray technologist, for example, to seek written consent every time a patient is positioned. Implied consent, in many cases, means that a patient demonstrates consent by his or her own behavior. The radiographer announces to the patient, "I am going to put a needle in your patella." Consent is inferred by the fact that the patient is sitting in a hospital gown outside the x-ray door, and came in with an x-ray slip. If the patient had been planning to refuse the procedure, refusal would have been made before actually reaching the x-ray room.

c. **Apparent vs. Actual Knowledge.** The difficulty with implied consent is that there is no way of knowing what the patient actually knows about the proposed procedure. The patient who presents him or herself outside the x-ray room may not realize, for example, that the radiographer will have to handle him or her to feel or palpate bones. But in general, voluntary submission, with apparent knowledge of the nature of a procedure, is recognized as implied consent by the courts.

IMPLIED CONSENT

In *O'Brien vs. Cunard Steamship Company* (Mass., 1891), the court found that Mrs. O'Brien had, In fact, given her implied consent to being vaccinated by extending her arm and accepting the vaccination without objection.

IMPLIED CONSENT BY REASONABLE INFERENCE FROM PATIENT CONDUCT

Individuals who join a line of people also receiving injections do so with apparent knowledge that an injection will be administered to them. Since they see the proceedings at the head of the line, they could withdraw from the line at any time up to the instant of injection. Thus, the person administering the injection may reasonably infer that the individual's voluntary submission indicates consent.

IMPLIED CONSENT IN AN EMERGENCY

In *Jacovach vs. Yocum* (Iowa, 1931), the court found implied consent for the removal of a mangled limb that had been run over in a train accident. The court accepted the physicians determination that the amputation was necessary to save the life of the patient.

d. **Presumed Consent in Certain Emergencies.** Another form of implied consent is presumed consent. In medical emergencies, consent is presumed to exist, especially when there is an immediate threat to life or health. Some courts have found implied consent to extensions of surgical procedures beyond the scope specifically authorized when unexpected conditions arise, especially when an extension or a modification is necessary to preserve the patient's life or health. These additional procedures, known as "extensions" or "modifications;" are covered by the extension doctrine. (Many surgical consent forms include explicit authorization of extensions or modifications to preserve the patient's life or health. This minimizes disagreements over the scope of authorization by providing an opportunity for the patient to state specific extensions or modifications that are expressly forbidden.)

extension doctrine: the doctrine that allows the physician the prerogative to extend care beyond the scope of express consent in an emergency.

SCOPE OF AUTHORIZATION DID NOT EXTEND TO SURGERY ON THE OTHER EAR

In *Mohr vs. Williams* (Minn., 1905*),* Anna Mohr consented to an operation on her right ear, During the surgery, the physician realized that surgery was actually required on the left ear, and so he proceeded with the left ear surgery. The physician was found liable for failing to obtain express consent for the particular surgery required.

CONSENT FOR REMOVAL OF A LEFT INGUINAL HERNIA DOES NOT IMPLY CONSENT FOR REMOVAL OF A RIGHT INGUINAL HERNIA

In *Kischinsky vs. McMahon (*N.Y., 1953*),* the patient sued the surgeon for repairing a right inguinal hernia, when consent had been given for surgery on an inguinal hernia on the left side. The patient was referred by his family physician to the surgeon for a left inguinal hernia, which the family physician had found on examination. The surgeon confirmed the existence of a left inguinal hernia upon examination and recommended an operation to repair it. On the day of surgery, a blackboard near the operating room erroneously indicated that an operation was to be performed on the patient's right inguinal hernia. The surgeon and his assistant actually found and repaired a moderate-sized hernia on the right side. But, the physician was found liable, anyway. A physician who fails to conduct a preoperative exam or check his or her records before an operation is negligent. By operating on the opposite side of the body than that which was intended, the physician was deficient in the degree of care, skill, and diligence provided.

1-7. EXPRESS CONSENT

Express consent, oral or written, is the preferred form of consent. There are a few procedures, especially those involving reproduction, for which some states require written consent. With the exception of these few procedures, either oral or written consent can be legally sufficient authorization. While, in theory, there is no difference between written or oral consent, it is difficult to prove that an effective oral consent was given. *Therefore,* most providers seek written consent.

> **express consent**: consent given by direct communication, either orally or in writing.

1-8. PROCEDURES REQUIRING EXPRESS CONSENT FROM MILITARY FAMILY MEMBERS

By regulation, written consent is required from military family members for: invasive surgery, anesthesia, treatment involving radioactive material, electroshock therapy (which is no longer widely used), and procedures involving more than a slight risk of harm. Routine procedures with only a slight risk of harm do not require the patient's express consent. The term "slight" is not defined in the regulation. Therefore, common sense and local policy will have to guide the health care provider in determining which procedures require express consent.

EXPRESS CONSENT FROM MILITARY FAMILY MEMBERS IS REQUIRED FOR:

Invasive surgery.
Anesthesia.
Treatment involving radioactive material.
Electroshock therapy.
Procedures with more than a slight risk of harm.

Figure 1-4 Procedures requiring the express consent of military family members.

1-9. CONSENT NOT REQUIRED TO TREAT SERVICE MEMBERS

A service member's right to give consent for treatment required to restore him or her to duty is more restricted. And, in fact, there are many circumstances in which consent is not required to treat a service member. (See figure below.) If a service member refuses to submit to medical care, a medical board will determine: 1) if the recommended care is necessary to restore the service member to duty; 2) if the recommended care is an established, ordinary medical procedure; 3) if refusal is unreasonable; and 4) if the likely outcome of treatment is good. If the service member still refuses treatment after the board, the results are forwarded to Headquarters Department of the Army (HQDA) for review. If The Surgeon General approves the board, and the service member still refuses treatment, then an order to comply can be given. If the service member disobeys the order to comply, he or she shall be subject to administrative or punitive action.

SERVICE MEMBER'S CONSENT NOT REQUIRED TO:

- Preserve the life of a service member.
- Alleviate undue suffering.
- Maintain the health of others.
- Provide immunization.
- Isolate and quarantine.
- Enforce detention on closed wards for the protection of the service member or others.
- Provide medical care related to mental disorders.
- Provide diagnostic medical care, physical exams, and associated procedures.

Figure 1-5. A service member's right to give consent is restricted. Anything done to maintain or restore the service member's deployability worldwide does not require consent.

1-10. CONSENT NO DEFENSE AGAINST NEGLIGENCE

Some physicians, nurses, and hospital administrators mistakenly assume that written consent constitutes a valuable defense against charges of professional negligence or malpractice. Written consent is, in fact, only valuable as evidence that the patient gave consent for the procedure. It is of no value against charges that the procedure was unnecessary or that the operator was guilty of professional negligence. And, it is of little value if the patient can prove that he or she could not reasonably have been expected to understand that for which he or she was asked to give consent. In other words, consent is not a patient waiver of the right to sue for negligence. It is only evidence that a procedure or treatment plan has been discussed.

1-11. ELEMENTS OF INFORMED CONSENT

a. **Competence (Decision-Making Capacity).** In order to obtain both an express (oral/written) and an informed (knowledgeable) consent, the patient must have certain characteristics, and must have made the decision under the right conditions. First, the patient must be competent to make decisions. This means being of legal age or emancipated (the parent has given up legal duties toward the child, e.g., the child has left home and is self-supporting). To make valid decisions, the patient must be able to take in and process information, that is, to reason. He or she must be able to communicate, not necessarily to speak, but at least to make wishes known, e.g., by blinking, nodding, and so forth. Also, the patient must be able to understand the consequences of his or her decisions.

b. **Information Disclosed and Understood.** The cornerstone of informed consent is providing the right information and making sure it has been understood. Not only must the physician provide the relevant information, but also there is an affirmative responsibility to ensure that the patient understands the information.

A SEDATED PATIENT CAN'T GIVE INFORMED CONSENT

Does the patient understand what the physician is saying? If after providing adequate disclosure, a physician has reason to believe that the patient has passively assented, merely gone along without understanding what he or she has been told, then there has been no legally effective consent. And in such a case the physician may be liable for battery. The obvious case is one in which the patient has been given a sedative which keeps him or her from understanding some aspect of the treatment. Consent obtained after sedation is probably not legally valid. A good, prudent physician will determine whether the patient "understands" what's been said.

c. **Consent, Voluntary and Authorized.** A patient's permission is not legally effective unless it is freely given without: duress, undue influence, or coercion. Authorization should be clearly communicated (preferably in writing).

(1) Health care providers. The knowledge and authority of the health care provider tends to foster a "doctor (health care provider) knows best" attitude that can unduly sway the patient. Remember that consent, in its most desirable form, is not merely assent with understanding. It is an active participation in the decision-making process, a give-and-take regarding the pros and cons to arrive at the most suitable treatment option.

(2) Family. Relatives who generally have the best interest of the patient at heart may, in some instances, try to talk the patient into having a procedure that is not really needed.

(3) Hospital environment. As stated earlier, a hospital is an inherently stressful environment for a patient. It is a strange place where a lot of unfamiliar things occur, many of which are painful. The ethical basis of legally valid consent is the individual's right to autonomy (self-rule or self-determination). Yet, the hospital is a place in which patients tend to give up the real-life autonomy they normally exercise, because something is wrong with them, and they don't really know what to expect.

ELEMENTS OF INFORMED CONSENT

PREREQUISITE
1. Patient competence.

INFORMATION
2. Disclosure of information (by the physician).
3. An understanding of the information (by the patient).

CONSENT
4 Voluntary in nature.
5. Formal authorization given.

Figure 1-6. Five elements of informed consent.

INFORMED CONSENT, A CLOSER LOOK

- A competent patient:
  - Can decide for him/herself.
  - Is of legal age or emancipated.
  - Can reason.
  - Can communicate wishes.
  - Understands the consequences of decisions.
- Relevant information is disclosed and understood.
- Consent is voluntary; patient is not coerced by:
  - Health care providers.
  - Family.
  - Hospital environment.
- Formal authorization is given.

Figure 1-7. Elements of informed consent, further specified.

RECAP-TYPES OF CONSENT

IMPLIED: -Inferred consent by circumstances or patient's actions.
-Presumed in a life-threatening.
-emergency.

EXPRESS: -Written or oral consent.

INFORMED: -Consent based on knowledge of appropriate information.

Figure 1-8. The preferred form of consent is both express and informed.

1-12. PURPOSE AND FORM OF ROUTINE WRITTEN CONSENT

a**. Purpose of Consent.** Routine consent is obtained in advance of procedures involving substantial risk. Such consent is obtained to protect the physician, nurse, and hospital against claims of unauthorized operations and to guard the patient against unsanctioned surgery. Written, rather than verbal, consent is the preferred form of express consent, because there is less room for controversy about proposed treatment and greater ease in legally substantiating that the patient had, in fact, given consent. Naturally, there must be apparent knowledge of the proposed procedure. The consent form doesn't have to describe the procedure in technical terms and in all of its minutiae, but it has to show that the patient had prior knowledge of the procedure. The signing of a blank consent form or one giving blanket consent to any and all procedures is of doubtful value, unless the proposed operation is duly specified. Written consent limits the surgeon's authority to that which is prescribed in the consent form. The surgeon cannot go beyond the authorized scope of the operation/procedure unless an emergency arises which makes additional consent impractical.

b. **Proof of Consent.** Written consent provides tangible proof of consent. To be valid, a written consent must be signed, it must specify the procedure being consented to, and it must show evidence of the fact that the patient has understood the nature of a procedure, the likely risks involved, and the probable consequences. The consent form must be dated and witnessed. In an x-ray clinic, the x-ray technologist will serve as the witness for routine procedures such as an angiogram or an intravenous pyelogram (IVP). The specific procedures requiring a written consent form will vary from hospital to hospital. In some military hospitals, routine procedures like an IVP require a consent form; in others, consent is only required for life-threatening procedures. In any case, the most satisfactory proof of consent consists of two integrated consent forms: an admission consent form and a special consent form.

(1) Admission consent form. The admission consent form covers routine hospital services, diagnostic procedures, and medical treatments. X-rays, lab work, and day-to-day routine procedures would fall into this category.

(2) Special consent form. A special consent form is obtained before every medical and surgical procedure or treatment that is not routine. For example, a CAT scan requiring injection of a contrast media would require a special consent form. (See next page for SF 522, "Request for Administration of Anesthetic or Performance of Operation and Other Procedures.")

1-13. MODELS OF INFORMED CONSENT

a. **Assent Without Understanding Not Informed Consent.** Beginning in the 1950's the rules of consent began to change. The fact that a patient had consented to treatment meant very little if, in fact, the patient had no idea as to what he or she was being asked to deliberate. The courts started imposing an affirmative responsibility on physicians to provide sufficient information in order for the patient to give an informed consent. (See paragraph 1-2 to review the definition of informed consent.)

b. **Institutional Model of Consent.** There is a limited interpretation of informed consent that does not entirely fulfill the higher ethical principle of patient self-rule. I n this sense, the hospital simply fulfill the regulatory requirements for obtaining a legally valid informed consent when relevant information is obtained. Thus, the physician (who informs the patient of the risks of a proposed intervention) ascertains that the patient has understood the risks, and then gets the patient to sign the proper authorization form fulfilling the institutional requirements for informed consent. This model of consent is a one-way communication process in which the physician transmits a body of information to the patient.

c. **Autonomy Model of Consent**. The real intent of patient consent is to support the patient's right to self-determination (autonomy). This means that the patient has a decisive role to play in the medical decision-making. The patient does more than just go along with a treatment plan. The patient actively authorizes the proposal in the act of consent. This authorization is a culmination of an ongoing dialogue between patient and physician aimed at discovering what is relevant to the patient and how to apply it to the patient's unique circumstances. Treatment options are discussed and consensus is reached on a treatment plan.

NSN 7540-00-634-4165

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____

(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

   a. The name of the patient and his/her family is not used to identify said pictures.

   b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

_____

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

SF 522

LEVELS OF INFORMED CONSENT

- **INSTITUTIONAL MODEL**
  - One-way communication.
  - Physician transmits body of information.
  - Patient understands and consents to intervention.
  - Patient signs the proper form with an understanding of the major risks.

- **AUTONOMY-BASED MODEL**
  - Two-way communication (dialogue).
  - Give-and-take between physician and patient.
  - Patient's unique circumstances and informational needs are identified.
  - Active involvement of the patient in Decision-making.
  - Patient and physician reach consensus.
  - Patient signs consent form.
  - Patient gives formal consent.

Figure 1-9. Levels of informed consent.

d. **Meeting the Requirements of One or the Other Models of Consent.** It is possible to fulfill the requirements of informed consent in the larger decision-making sense (the autonomy model), and yet not fulfill the more limited institutional requirement for a legally valid authorization. A patient can autonomously authorize an intervention, thereby giving an informed consent in the first sense. (He or she has had a series of discussions with the physician on the pros and cons of alternative treatment plans, thought about the options, and in a give-and-take has decided upon a treatment plan with which both physician and patient are satisfied.) All the same, the patient might not effectively authorize that intervention on the appropriate form, thus not giving an informed consent in the second sense. An example of this is the minor who cannot legally give consent, but who has participated in a decision-making process on the course of treatment. What the courts require for informed consent is that the physician has outlined the risks of a proposed intervention, the patient has understood those risks, and the signature on a consent form has been obtained

e. **Meeting the Requirements of Both Models of Consent.** Hopefully, informed consent, as it is practiced in the real world, will encompass both models of consent: participation in decision making and a legally valid authorization based on knowledge of the risks. The goal of informed consent is to enable patients to make autonomous decisions about whether or not to authorize medical intervention.

f. **The Role of Disclosure in the Institutional Model of Informed Consent.** In the more limited interpretation of informed consent, consent is often seen as the obligation to inform patients. The legal doctrine of informed consent has been primarily a law of disclosure, based on a general obligation to exercise reasonable care by giving information. In this sense, the health care professional has a body of information that needs to be transmitted.

g. **The More Limited Role of Disclosure in the Autonomous Decision-Making Model of Informed Consent.** As stated above, disclosure plays an important role in the legal/institutional definition of informed consent. However, from the moral point of view, informed consent has less to do with disclosure, and more to do with *autonomous choices* of patients and subjects. In the institutional sense, the health care professional is seen as having a body of information to transmit. This is a one-sided, physician-centered activity. But when the broader definition of informed consent is considered, there is an information exchange between physician and patient that is decidedly two-way. There is a dialogue, an exchange of questions and answers on both sides, when joint decision-making is taking place. In this context, transmission of information is less important. The patient may already have all the information. What's important is discovering what information is relevant and how to apply it to the patient's unique circumstances. This is not to say that disclosure is unimportant. It is a necessary foundation for any decision-making. Without an adequate transfer of information, many patients and subjects will have insufficient information for decision-making. The physician's opinions and recommendations are, after all, an important component of the patient's decision-making process.

DOES THE PATIENT WANT AUTONOMY OR BENEFICENCE (PATERNALISM), OR BOTH?

Dr. Christine Castle, Medical Ethicist and Chief of Internal Medicare at the University of Chicago Medical Center, points out that it may, at times, be hard for the one to engage in truly autonomous decision making at the very moment when sickness saps your energy and impairs your freedom. This happens whether you are suffering from a minor sickness like a sore throat or a broken leg, concerned that you might have AIDS, or in terrible fear of cancer. She refers to a poignant article entitled, "On Arrogance," written by a terminally ill physician for one of the professional journals. The physician, suffering from terminal cancer and technically competent to make treatment decisions, soon realized that what he really wanted was a knowledgeable, ethical, competent person helping him to make decisions. He didn't want total freedom or a menu of possible treatments similar to what one might receive from an auto mechanic. He wanted someone with an opinion on the best possible treatment; someone with whom to share the responsibility for decisions; someone who cared. Or, Castle observes that there is no way the relationship between physician and patient can be equal. The patient is dependent upon the physician for so many things, from a prescription to a note to miss a day of work, to all the bureaucratic entitlements and benefits. She concludes that in all our emphasis on the patient as being free and uncoerced we lose sight of the need for caring. Of course, the patient wants to be treated with respect, and does not want his or her options unduly constrained. But, at the same time, the patient wants a caring physician who is ready to share in the responsibility?

beneficence: the concept that the role of the health care provider is to care for the patient, to do good.

paternalism: the practice of treating people in an authoritarian manner, especially by taking care of their needs without giving them any responsibility for health care decisions.

Continue with Exercises, Section I

EXERCISES, LESSON 1, SECTION I

It is recommended that you work the following exercises (1 through 27) before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MATCHING. For exercises **1 through 7**, match the term in the left-hand column with the appropriate definition in the right-hand column. (There is one extra definition.)

___ 1. Implied cones (inferred).

___ 2. Presumed consent.

___ 3. Express consent.

___ 4. Informed consent.

___ 5. Autonomy model of informed consent.

___ 6. Institutional model of informed consent.

___ 7. Extension doctrine.

a. Consent in which the patient merely assents without a real understanding of proposed treatment.

b. Consent that is suggested by circumstances or the patient's actions.

c. Consent given by direct word, either orally or in writing.

d. Consent that is assumed to exist in an emergency situation.

e. Consent as a free and rational act based on knowledge of the relevant issues pertinent to treatment options.

f. The doctrine that allows procedures beyond the scope specifically authorized in life-threatening emergency situations.

g. Consent based on a one-way communication of information from physician to patient.

h. Consent based on an ongoing dialogue between patient and physician, in which the patient's unique needs are considered. The patient takes an active role in selecting treatment options.

MULTIPLE-CHOICE. For exercises **8 through 21,** select the **ONE** response (a, b, c, or d) that **BEST** completes the statement or **BEST** answers the question.

8. An individual joins a line of people receiving injections and sees the proceedings at the head of the line. The health care provider administering the injections may reasonably assume that:

   a. The individual's voluntary submission and apparent knowledge of the procedure implies consent.
   b. Written consent will be required.
   c. Oral consent is needed.
   d. Injecting the patient without his or her express consent would constitute battery.

9. If a physician fails to obtain express consent before performing invasive surgery on a nonmilitary patient, he or she is likely to be found guilty of:

   a. Assault.
   b. Battery.
   c. Negligence.
   d. Defamation.

10. A physician fails to discuss risks and other relevant information before administering anesthesia to a nonmilitary patient. The patient sues the physician for:

    a. Liable.
    b. Assault.
    c. Negligence.
    d. Battery.

11. A train wreck victim is brought into the emergency room unconscious. His arm is irreparably mangled, and he will die unless the arm is amputated. The physician determines that the mangled arm will have to be amputated without delay. This decision is:

    a. Based on implied consent presumed to exist in a life threatening emergency.
    b. Based on express consent with prior knowledge of the procedure.
    c. Based on the elements of disclosure for informed consent.
    d. Likely to result in legal action for battery, as consent was not obtained.

12. A formula for implied consent that is inferred from the patient's behavior would be:

a. Involuntary submission without apparent knowledge.
b. Involuntary submission with apparent knowledge.
c. Voluntary submission without apparent knowledge.
d. Voluntary submission with apparent knowledge.

13. A blanket written consent that doesn't specify the procedure or operation to which the patient is giving consent is inadequate because it does not document:

a. Apparent knowledge.
b. Implied consent.
c. An ability to communicate.
d. Competence.

14. Providing the necessary information to patients may pose problems for the physician because: complex treatment may be hard to explain adequately, there are things the patient may prefer not to know, and/or an explanation may:

a. Lead to lawsuits.
b. Feed irrational fears.
c. Result in refusal rather than consent.
d. Require translation.

15. Which of the following supports the autonomy model of patient consent before the consent form is signed by the patient:

a. The physician outlines the benefits, risks, and alternatives to a proposed treatment plan.
b. The patient is told not to worry and asked to sign the consent form.
c. The patient and physician engage in a give-and-take on options in order to decide on a treatment plan suited to the unique needs of the patient.
d. The medical ethicist independently researches alternative treatment plans on behalf of the patient.

16. Which of the following describes what happens before signing the consent form in the more limited institutional sense of informed consent?

a. There is only an implied consent.
b. The physician outlines risk-benefit factors for the patient, and ascertains that the patient has understood them before giving consent.
c. The patient gets a second opinion.
d. The physician and patient engage in an ongoing dialogue on treatment care options.

17. Which of the following describes the institutional model of informed consent?

a. The actual disclosure of information is less critical than obtaining the signature on a consent form.
b. Patient autonomy is of paramount importance.
c. Disclosure is a one-way process, with the physician transmitting a body of information.
d. The information provided is tailored to the unique needs of a particular patient.

18. Because of the requirement to maintain or restore a service member's deployability worldwide, the service member's right to give consent for treatment is:

a. Restricted.
b. Equal to that of civilians.
c. Greater than most.
d. Equal to that of family members.

19. An 86-year-old diabetic with a history of heart failure is admitted to the emergency room for chest pains. He is admitted to the intensive care unit (ICU) where it is discovered that he has suffered a heart attack. The next day a bed is needed in the ICU for another patient. The diabetic is asked if he would mind being moved to a regular floor. He consents to the move. He is not told that on a regular ward there will be no cardiac monitor. Which of the following statements characterizes this situation?

a. The patient's right to self-determination was upheld.
b. The patient's consent was implied.
c. There was express consent but not informed consent, as risks and benefits were not outlined.
d. The patient was incompetent to give consent.

20. Under the autonomous decision-making model of informed consent, the most important element of consent is:

a. Full disclosure.
b. A dialogue aimed at discovering the relevant information and how it applies to the patient's unique circumstances.
c. A one-way communication from patient to physician.
d. Transmission of a body of information from physician to patient.

21. A patient can be coerced into giving consent through direct or indirect pressure exerted by health care providers, family members, and/or:

a. The patient him- or herself.
b. One's values, beliefs, and attitudes.
c. The hospital environment.

22. Which statement is NOT applicable to express consent?

a. It can be oral or written.
b. Written consent is required for certain procedures.
c. It is a form of implied consent.
d. It may be difficult to prove that an effective oral consent was given.

23. Which is NOT a characteristic of informed consent?

a. It is the free and rational act of a competent patient.
b. It presupposes substantially correct knowledge of proposed procedures.
c. It is primarily the physician's responsibility to obtain consent.
d. It is presumed to exist.

24. Express consent from a military family member is NOT required for:

a. Invasive surgery and anesthesia.
b. Treatment involving radioactive material.
c. Electroshock therapy.
d. Routine procedures.
e. Procedures involving more than a slight risk of harm.

25. Which is NOT a prerequisite for a patient to be considered competent to give an informed consent?

a. Being of legal age or emancipated.
b. An ability to reason and communicate.
c. An ability to understand the consequences of one's decisions.
d. An ability to speak.

26. Which is NOT an element of informed consent?

a. Patient competence (decision-making capacity).
b. A minimum high school education.
c. Voluntariness of the authorization.
d. Disclosure and understanding of information.
e. Authorization given.

27. Which is NOT a desirable feature for a written consent form?

a. Blanket consent.
b. Dated and signed.
c. An integrated admissions and special consent form.
d. Duly witnessed.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1, SECTION I

1. b (para 1-6a & figure1-3)
2. d (para 1-6d & fig figure 1-3)
3. c (para 1-7)
4. a (para 1-2b)
5. h (para 1-13c & figure 1-9)
6. g (para 1-13b & figure 1-9)
7. f (para 1-6d)
8. a (para 1-6b & anecdote, "Implied Consent ... Conduct.")
9. b (para 1-3b & anecdotes, "Plastic Surgeon..:" and "Surgeon Liable...")
10. c (para 1-3c)
11. a (para 1-6d & figure 1-3)
12. d (para 1-6a)
13. a (para 1-12a)
14. b (para 1-5b)
15. c (para 1-13c & figure 1-9)
16. b (para 1-13b)
17. c (para 1-13b)+
18. a (para 1-9 & figure 1-5)
19. c (paras 1-5a & 1-7)
20. b (para 1-13c)
21. c (para 1-11c(3))
22. c (para 1-7)

23. d (para 1-11 & figure 1-6)

24. d (para 1-8 & figure 1-4)

25. d (para 1-11 & figure 1-7)

26. b (para 1-11 & figure 1-6)

27. a (para 1-12a & b)

Go to **Section II**

Section II: DISCLOSURE

1-14. DISCLOSURE STANDARDS FOR INFORMED CONSENT

a. **Two Different Standards Plus Hybrids**. It is neither feasible nor desirable to tell the patient everything that could possibly happen as a result of treatment decisions (in other words, full disclosure). Therefore, the courts have developed two standards for determining the adequacy of a physician's disclosure: the professional practice standard and the reasonable person (material risk) standard, with two variations (the objective and subjective tests). Some states have developed hybrids of these tests. Although a number of disclosure standards do exist, the physician must comply with disclosure requirements of state law.

b. **Professional Practice Standard.** The courts in many states use the professional practice standard. In those states, the physician's duty is to disclose what any reasonable medical practitioner would disclose in the same or similar affair. (This standard supports the institutional model of consent, discussed earlier, in which the physician transmits a body of information in an essentially one-way communication.) *Medical standards,* rather than the patient's rights, are the operative guidelines for disclosure under this standard.

> **professional practice standard of disclosure:** a standard of disclosure that requires the physician to disclose what any reasonable health care provider would communicate in the same or a similar circumstance.

There are some problems with this standard. First, it assumes that a customary standard exists. In many medical situations a standard may not exist regarding the communication of information. Secondly, if a standard of disclosure does exist for a certain procedure but is set too low, then the patient's right to information is undermined by the legal standard. And finally, and most importantly, the professional practice standard can undermine the patient's right of autonomous choice. This standard reflects the assumptions, values, and goals of a medical mindset. But, decisions for or against medical care are, in large measure, no medical judgments made by the patient, and are rightly the domain of the patient. It may also be questioned whether physicians really know what information is in the best interests of the patient. The weighing of risks against a patient's *unique set* of subjective beliefs, fears, and hopes cannot be measured through a professional standard. What is important to one patient may not be important to another.

PROFESSIONAL PRACTICE STANDARD OF DISCLOSURE

- The kind and amount of information are determined by what any physician would disclose in a similar situation.
- It supports the institutional model of consent.
- There is a one-way transmittal of a body of information.

Figure 1-10. Professional practice standard.

c. **Reasonable Person (Material Risk) Standard.** For the reasons stated above, the reasonable person standard has gained acceptance in 60 percent of the states in the United States. Under this standard, the kind and amount of information are determined by reference to a hypothetical reasonable person. The relevance (materiality) of a piece of information is measured by the significance a reasonable person would attach to it in deciding whether to undergo a procedure. By this standard, informational needs are determined by the *patient,* not the physician. The underlying basis for this standard is the belief that informed consent is a doctrine, designed to permit patients to be the agents of decision making and authorization. (Thus, this standard supports the autonomy choice model of consent discussed earlier.)

REASONABLE PERSON STANDARD OF DISCLOSURE

- The kind and amount of information are determined by reference to:
- A hypothetical reasonable person (the objective test).

OR

- The unique informational needs of the actual person (the subjective test)
- It supports the autonomy model of consent.
- There is a two-way dialogue.

Figure 1-11. The reasonable person model supports the patient's right to self-determination in making health care decisions.

PROFESSIONAL PRACTICE STANDARD OF DISCLOSURE

In *Natanson vs. Kline* (Kansas, 1960*),* cobalt radiation (a relatively new procedure for the time) was administered following a radical mastectomy. After suffering serious side effects from the therapy (injuries to the chest, skin, and cartilage), the patient sued the physician. The physician acknowledged that he had failed to warn the patient of the risks that were inherent in this procedure. This case established a category of risks that must be disclosed to the patient. The question of how disclosure should best be made was judged to be primarily one of medical judgment. The duty of the physician is to make "those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." This is the standard established in the early cases and the one that is still law in the majority of jurisdictions.

REASONABLE PERSON (MATERIAL RISK) STANDARD OF DISCLOSURE

In *Canterbury vs. Spence* (Wash. D.C., *1972),* a laminectomy (surgical removal of the posterior arch of a vertebra) was performed for severe back pain. On the following day, the patient fell out of bed causing major paralysis. The patient had not been warned that a laminectomy might increase the danger of paralysis as a result of such eventualities as falling out of bed. A second operation failed to relieve the paralysis, and though the patient did improve, he never returned to normal. The court ruled that information "material" to the decision must be disclosed. It said that a risk was material "when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." The court went on to say: "...the patient's right of self-decision... can be exercised only if the patient possesses enough information to enable an intelligent choice."

(1) Objective test. The original reasonable person standard applies an *objective* test*,* which measures the individual patient against a *reasonable person* standard. It asks what information a reasonably prudent person in the patient's position would consider material if informed of the same risks. This standard is not without its problems. "Material information" and the concept of a reasonable person have never been thoroughly defined. (Who, exactly, is this prototype of the reasonable person?) It is difficult, at times, for physicians to anticipate what a reasonable person might need to know. But, for all its shortcomings, the reasonable person standard better serves the patient's needs in coming to a personal decision on treatment procedures than the professional practice standard.

(2) Subjective test. A subjective test of the reasonable person standard was later developed. The subjective test goes one step farther by recognizing that the informational needs of an *objective* reasonable person may not meet the unique and specific needs of a *real* patient.

> **subjective test of the reasonable person standard of disclosure:** the standard whereby the physician's duty to disclose information material to the decision is determined by the informational needs of the *individual* patient.

The reasonable person standard of disclosure (subjective test) goes the farthest to support the autonomy choice model of informed consent, discussed earlier, in which a two-way dialogue establishes the unique informational needs of the patient. Informational needs can differ. For example, a person may have unorthodox beliefs, unusual health problems, or a unique family history that requires a different information base than the hypothetical objective reasonable person.

INFORMATIONAL NEEDS CAN DIFFER

In *Hales v. Pitman* (Ariz., 1978), the patient told the physician that his ability to work was crucial, so the court ruled that the physician should have informed him of the risks that could affect his ability to work. This ruling illustrates that when a patient indicates a need for special information, unique to his or her situation, there can be a duty to provide it. A female employee with a family history of reproductive problems might need information that other persons would not need, before becoming involved in research on sexual and family relations or before accepting employment in certain industries.

d. **Hybrid Standards.** Some states have developed hybrid standards. For instance, in Texas there is the "A list" which delineates certain procedures and what the patient must be told about them. The "B list" contains another group of procedures for which there is no obligation to inform the patient about potential risks, unless the physician so desires. Interestingly, there are no gynecological procedures on the "A list," even though the obstetrics-gynecology (OB-GYN) specialty is recognized as having a high incidence of malpractice suits.

• **FULL DISCLOSURE**	All risks, likely and remote, are disclosed. (Impossible/undesirable standard.)
• **PROFESSIONAL PRACTICE STANDARD**	What a reasonable physician would disclose under the same or similar circumstances.
• **REASONABLE PERSON (MATERIALRISK) STANDARD**	
-OBJECTIVE TEST	What a hypothetical reasonable patient would view as "material" is disclosed.
-SUBJECTIVE TEST	The unique informational needs of the particular patient determine what is disclosed.
• **HYBRID STANDARDS**	Example: List A (Required disclosures). List B (Optional disclosures).

Figure 1-12. Standards of disclosure.

REASONABLE PERSON STANDARD OF DISCLOSURE AND UNIQUE INFORMATIONAL NEEDS

While it is not necessary or desirable to outline *all* possible risks, it is important to take into account the unique informational needs of each patient. For example, a concert pianist requiring surgery would need to know about the possible risks of a 10 percent loss of motion in the hand, that could result from an operation. For the pianist, such a risk, however remote, would be crucial since the pianist's livelihood and creative fulfillment require full range of fine motor skills of the hand. On the other hand, a day laborer, undergoing the same surgery, would probably not consider this risk particularly relevant. (Other information might be crucial based, perhaps, on family health history or other factors.) Less severe or less probable risks may be relevant and important to a particular patient. Thus, the dialogue between physician and patient is important in ascertaining the patient's unique informational needs.

1-15. ELEMENTS OF DISCLOSURE

a. **Providing the Information That Will Facilitate The Patient's Decision Making.** Professionals are obliged to disclose a core body of information. Without an adequate transfer of information, many patients will have insufficient information for decision-making. The health care professional's perspective, opinions, and recommendations are often useful and relevant for the patient's consideration, as well as for mutual understanding. Even if not always essential, the provider's input is certainly useful and relevant.

b. **What to Disclose.** The purpose and nature of authorization as an act of consent should be explained. The facts that patients usually consider relevant in deciding whether to refuse or consent to intervention should be covered. And, any information that the physician believes to be relevant, together with the clinician's own recommendations, should be outlined. All explanations should be made in layman's terms, so that they can be easily understood. The usual elements of an explanation are summarized below.

(1) The purpose and nature of authorization as an act of consent. (Self-explanatory; see paras 1-2 and 1-5.)

(2) The nature of the treatment. This is a statement of the patient's condition or problem and an explanation of the nature and purpose of the proposed treatment.

(3) Possible and probable benefits of treatment. (Self-explanatory.)

(4) Probable risks and consequences (seriousness and frequency). A reasonable disclosure of the dangers that are possible is required. This does not mean that the physician is obliged to describe in detail all of the possible consequences of treatment. In fact, full disclosure (an explanation of all facts, diagnoses, complications, and alternatives) would be bad medical practice, as it would unduly alarm and confuse the patient. Only risks that are known (or should be known) by the physician to occur without negligence must be disclosed. Nearly all courts recognize that not all risks can be disclosed. One useful guideline is to disclose the risks that have a large probability of occurring and those with the most severe consequences. The seriousness of the risk (for example, temporary paralysis) and the frequency of occurrences (for example, a 75 percent chance) should be discussed. Under the reasonable person standard (subjective test), theunique informational needs of the patient should also be taken into account. A remote risk that is not relevant to most patients might be crucial to some, depending on the patient's beliefs, medical history, lifestyle, and so forth

(5) Feasible treatment alternatives and their likelihood of success. Accepted alternatives that are reasonable should be discussed.

(6) Consequences of not treating. (Self-explanatory.)

(7) Names, of person s, responsible for treatment or procedure. (Self-explanatory.)

1. The purpose and nature of authorization as an act of consent.
2. The nature of the treatment (surgical procedure or drug therapy).
3. Possible and probable benefits of the proposed treatment.
4. Probable risks and consequences.
   a. Seriousness (temporary paralysis of the arm)
   b. Frequency (a 75 percent chance).
5. The feasible alternative treatments and their likelihood of success.
6. The consequences of not treating.
7. Name(s) of person(s) responsible for treatment or procedure.

Figure 1-13. Element of disclosure.

1-16. PURPOSE OF DISCLOSURE

The disclosure requirements were not designed to protect the physician from medical malpractice suits. Thus, the elements of disclosure cannot simply be viewed as a handy laundry list of "right things" to cover to ensure protection from medical malpractice suits. Rather, the goal of disclosure is patient-centered. The intent is to support the patient's right to self-determination (autonomy) in decision making by enabling patients to exercise their autonomy rationally and intelligently. The emphasis should be on options rather than risks (although failure to advise of the risks could definitely get the physician in trouble).

Continue with Exercises, Section II

EXERCISES, LESSON 1, SECTION II

It is recommended that you work the following exercises (1 through 11) before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response (a, b, c, or d) that **BEST** completes the statement or **BEST** answers the question.

1. Which standard of disclosure reflects the assumptions, goals, and values of a medical mindset rather than the patient's beliefs, fears, and hopes?

   a. The professional practice standard.
   b. The reasonable person standard (objective test).
   c. Hybrid standards.
   d. The material risk standard (subjective test).

2. Which of the following shifts the determination of informational needs from the physician to the patient?

   a. The professional practice standard of disclosure.
   b. The reasonable person (material risk) standard of disclosure.
   c. Professional codes of ethics.
   d. "The thing speaks for itself" doctrine.

3. Which standard of disclosure does the most to take into account unorthodox beliefs, unusual health problems, and unique family histories?

   a. The professional practice standard.
   b. The objective test of the reasonable person standard.
   c. Hybrid standards.
   d. The subjective test of the reasonable person standard.

4. When disclosing risks and consequences to the patient, the physician should, at a minimum, outline:

   a. All risks known by the physician.
   b. Risks resulting from negligence.
   c. Probable risks, those with the most severe consequences and those particularly relevant to the patient.
   d. All risks known to medical science.

5. The purpose of disclosure is to:

   a. Protect the physician from medical malpractice.
   b. Enable patients to exercise their autonomy by intelligently selecting treatment options.
   c. Foster paternalism in health care, and give the patient the benefit of full disclosure.
   d. Emphasize the potential risks rather than treatment options.

6. The professional practice standard assumes that:

   a. A customary standard of disclosure exists for the communication of information.
   b. The physician can put him- or herself in the patient's place.
   c. Patient autonomy is the most important consideration.
   d. The standard of disclosure can never be set too high.

7. According to the material risk standard of disclosure, the materiality (relevance) of a piece of medical information is measured by the significance that a _____ would attach to it in deciding whether or not to undergo a medical procedure.

   a. Physician.
   b. Hospital administrator.
   c. Medical ethicist.
   d. Hypothetical reasonable person.

8. The problem with the objective test of the reasonable person standard is that:

   a. Material information and the concept of the reasonable person have never been thoroughly defined.
   b. It is doctor-centered.
   c. It meets the unique needs of any patient.
   d. It goes too far in supporting the ethical principle of the patient’s right to self-determination.

9. Which is NOT an element of disclosure?

a. Treatment options (recommendations and alternatives).
b. The benefits and risks of treatment; risks of not treating.
c. The purpose and nature of authorization as an act of consent.
d. The name(s) of person(s) responsible for the treatment or procedure.
e. All possible risks and complications.

10. A female patient, who is a single working parent, consents to repeat surgery on a hiatus hernia. The physician does not mention that it may be necessary to open the patient's chest during surgery. (He won't know if this is necessary until she is on the operating table.) It turns out that there is no need to open her chest, and the operation and recovery are uneventful. In view of the general trend toward patient's rights and the reasonable person standard of disclosure, what would the patient's likely reaction be to such an omission of information, had it been necessary to open her chest?

a. She would be glad not to know. Even if she consented to having her chest opened, informing her would have caused unnecessary worry, a kind of harm.
b. If it turned out that opening the chest wasn't necessary, the doctor would have saved her needless worry by not telling her about that possibility in the first place.
c. Even if the chest had to be opened, the patient would be so grateful for the relief from hernia pain, that she would not resent having not been told.
d. Horrified by the size and pain of the incision and unprepared for a long absence from work, she might sue the surgeon and hospital for failing to disclose relevant information.

11. The professional practice standard of disclosure requires that the physician tell the patient:

a. All possible risks and benefits, likely and remote.
b. What an objective reasonable person in the same or similar circumstances would need to know.
c. What any reasonable medical practitioner would disclose in the same or similar circumstances.
d. What the particular patient in question needs to know.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1, SECTION II

1. a (para 1-14b)
2. b (para 1-14c)
3. d (para 1-14c(2))
4. c (para 1-15b(4))
5. b (para 1-16)
6. a (para 1-14b)
7. d (para 1-14c)
8. a (para1-14c(1))
9. a (para 1-15b(4))
10. d (para 1-14c)
11. c (para 1-14b)

Go to Section III

Section III: EXCEPTIONS TO DISCLOSURE

1-17. INTENTIONAL NONDISCLOSURE

The courts have recognized situations in which there is justification for less complete disclosure, although consent must still be obtained. These exceptions to disclosure include: therapeutic privilege, emergencies, patient incompetence, patient waiver, and prior patient knowledge.

1-18. THERAPEUTIC PRIVILEGE

a. **Introduction.** Therapeutic privilege, the most controversial exception to the disclosure requirement, allows that the physician may intentionally and validly withhold relevant information. The decision to withhold such information must be based on a "sound medical judgment" that to divulge the information would be potentially harmful to a depressed, emotionally drained, or unstable patient.

> **therapeutic privilege:** the physician's prerogative to withhold information if he or she reasonably believes that the patient's mental or physical well-being would suffer as a result of learning the information.

b. **Protecting the Patient from Harm.** If the physician determines that the patient's anxiety level is such that a normal disclosure could be detrimental to the effectiveness of the required treatment, therapeutic privilege may be exercised. Therapeutic privilege, however, cannot be invoked solely out of a concern that disclosure might cause the patient to refuse treatment. Depending on state law, the physician may have to provide the omitted information to the next of kin, and obtain concurrence from the relative on the patient's consent form. Although the physician may have decided to withhold information about risks, he or she still must disclose other information (for example, benefits) to the patient. Thus consent must still be obtained from the patient. But, it is based on a limited disclosure of the relevant facts. Thus, the patient ends up giving express consent based on limited disclosure. Although patient autonomy is the goal of consent, there are circumstances in which patients may have a deep need for a health care professional who assumes authority and with reassuring confidence issues orders that can aid the patient's recovery. Human needs for such authority are common in a medical context and complicate the process of reaching decisions with patients. (Refer back to anecdote in para 1-13g: "Does the Patient Want Autonomy or Beneficence or Both?")

Situations in which the physician might opt to exercise therapeutic privilege:

A confused, frightened cardiac patient.
A hope-exhausted, chronically depressed, kidney-dialysis patient.
A patient with metastatic cancer who faces treatment alternatives with terrifying risks.

Figure 1-14. Therapeutic privilege.

c. **Avoiding Risk of Any Counter Therapeutic Harm Whatsoever.** The way that therapeutic privilege is applied varies across legal jurisdictions. Some courts permit physicians to withhold information if disclosure would cause any counter therapeutic deterioration whatsoever (be it physical, psychological, or emotional). For example, if the physician has a patient with a weak heart, should the physician risk a possible heart attack by telling the patient about a suspected cancer? The physician may decide to withhold this information, or may opt to announce it with carefully chosen words: "I see a growth that I'm concerned about. We need to do a biopsy to check it out."

MISUSE OF THERAPEUTIC PRIVILEGE (A HYPOTHETICAL CASE

You have been referred to the orthopedics department for a knee injury (a very common complaint in the Army). The physician, CPT Rosemary Smythe, recommends knee surgery. She explains the risks and benefits and provides other relevant information. But, she fails to mention that a knee brace would probably be just as effective in correcting your condition as an operation.

You assume that you are getting the advice of an experienced physician. But in fact, you are being treated by a physician who is just out of medical school and completing her residency in the Army. CPT Smythe has a hidden agenda. Before this young resident can take the orthopedic boards, she needs to have performed ten knee reconstructions. The surgery she is proposing for you would be her tenth knee reconstruction.

In this example, CPT Smythe has withheld relevant information for her own purposes, not to your benefit. The failure to disclose this information would constitute a misuse of the therapeutic privilege. (There are, in fact, built-in safeguards against such an occurrence. In the military, you can automatically get a second opinion if your primary physician is a resident. If the second physician confirmed the need for a knee surgery, your consent would be expected. For the most part, you cannot refuse treatment required to make you fit for service. However, if you refused knee surgery, but could still do your job to include the two-mile run for physical training, you would not be discharged from service)

d. **Risk of Jeopardizing Success of Treatment or Impairing Decision - Making Abilities.** In some jurisdictions, the physician can withhold information if, and only if, the patient's knowledge of the information would have serious health-related consequences,for example, jeopardizing the success of treatment or critically impairing relevant decision-making processes through psychological harm. In the example cited above, if the physician thought that revealing the suspected cancer would result in a heart attack, he or she might exercise therapeutic privilege. If there will be pain associated with the proposed procedure, the physician must still disclose that information to the patient, even though it might complicate or hinder treatment. The patient can demand to know more about the pain and discomfort before giving consent. In such a situation, some physicians, who simply wish to avoid the nuisance of an emotional scene with the patient, may choose to exercise therapeutic privilege and discuss the proposed procedure with the spouse or close relative of the patient instead. This is not entirely fair to the patient because it deprives the patient, in some measure, of the right to autonomous decision-making.

e. **Risk of Rendering the Patient Incompetent.** In the strictest interpretation, the therapeutic privilege can be validly invoked only if the physician reasonably believes that disclosure would render the patient incompetent to consent to or refuse treatment. It might appear that protecting a patient from harm could conflict with the overall aim of informed consent (respecting a patient's right to autonomous decision making). To invoke therapeutic privilege under this last condition would not, in principle, conflict with respect for autonomy because the patient would be in no condition to make an autonomous decision if he or she were to become incompetent.

f. **Limitations on Therapeutic Privilege.** Courts have carefully limited therapeutic privilege to avoid abuses. As stated earlier, it is not applicable when the sole basis is physician concern that the information might lead the patient to avoid needed therapy.

LEVELS OF THERAPEUTIC PRIVILEGE

Depending on the jurisdiction, therapeutic privilege may be exercised when there is a risk of:

- Any counter therapeutic harm (physical, psychological, or emotional) from disclosure. (Most liberal interpretation.)
- Jeopardizing success of treatment or impairing decision-making abilities.
- Rendering the patient incompetent to consent or refuse. (Strictest application.)

NOTE: Therapeutic privilege cannot he exercised solely for fear that the patient will refuse the therapy.

Figure 1-15. Levels of therapeutic privilege.

g. **Disclosing Withheld Information to a Relative.** Physicians can only rely on therapeutic privilege when they can document that a patient's anxiety is significantly above the norm. If information is kept from the patient, the information must still be disclosed to a relative. Before the procedure can be performed, the informed relative must concur with the patient's consent to the procedure.

TELLING THE NEXT OF KIN

A pregnant woman with an inordinate fear of surgery and a history of heart problems goes into labor. As the labor progresses, it becomes increasingly apparent that the baby, who in the breech position, will have to be delivered by Caesarean section. In view of the woman's weak heart and expressed fear of being operated on, the physician decides to exercise therapeutic privilege, withholding the fact that the baby will have to be delivered by C-section. The husband is informed that delivery will be by C-section and his consent is duly obtained. This possibility had been discussed by the physician and the woman's spouse prior to delivery. Risks and benefits of a Caesarean delivery had been covered with the spouse earlier and his permission had been obtained at that time.

UNDER THERAPEUTIC PRIVILEGE

At a minimum, the physician obtains from the patient:

- Express consent based on limited disclosure.

The physician may also have to obtain from the next of kin:

- Express consent based on the knowledge of all relevant facts.

Figure 1-16. Disclosure/consent requirements under therapeutic privilege.

1-19. EMERGENCIES

a. **General.** In emergencies, when consent is presumed to exist, there is a parallel modification of the disclosure requirement. When there is no time to secure consent, there is clearly no time to make disclosures. In *Crouch* vs. *Most* (N.M., 1967), the court recognized that even when there is time to secure consent, emergency situations may still leave time for only an abbreviated disclosure.

b. **The Extension Doctrine.** The traditional rule has been that the physician cannot exceed the scope of permission he or she was given, that is, only those procedures specifically authorized by the patient can be performed. More recently, the courts have begun to recognize the medical reality that it is usually more sensible to perform any necessary additional procedure as part of the originally authorized procedure. If a *life-threatening* situation arises *during surgery*, which was not covered by the consent form because it was unknown, then consent of a family member may be sought. But, if the situation is so emergent as to prevent that, then the extension doctrine may be applied and no consent is necessary in order to save the patient's life.

EXTENSION OF CONSENT

In *Kennedy vs. Parrott* (N.C., 1956*),* the surgeon punctured some cysts that he found on the patient's ovaries during an appendectomy (for sound medical reasons), although he had no express authorization to do so*.* The court found an implied extension of consent, even though the extended procedure resulted in phlebitis, which necessitated additional surgery. The court recognized the surgeon's autonomy to react to unexpected conditions that could not be known beforehand, especially since the cysts were within the realm of eyesight of the original incision.

EXTENSION OF CONSENT NOT FOUND

In *Wells* vs. *Van Nort* (Ohio, 1919), a surgeon was held liable for removing a patient's ovaries and fallopian tubes when express consent had only been given for an appendectomy. The doctor's defense that the organs were diseased was rejected on several grounds. There is an implied prohibition against any procedure not expressly consented to. In addition, implied consent to removal of a body part or reproductive capacity is usually not found.

1-20. PATIENT WAIVER AND PRIOR PATIENT KNOWLEDGE

a. **Patient Waiver.** There is no legal obligation to disclose information that the patient does not wish to hear. But, physicians must be careful with this doctrine, as it can only be relied upon when the patient has clearly expressed his or her wish not to receive that information. The physician should find out why the patient does not want to know any of the particulars, and should see if there is any way in which it would be acceptable to the patient to receive said information. A waiver is very risky because if there is subsequent discontent or a bad result, it may be difficult to establish that the waiver was not physician-initiated.

b. **Prior Patient Knowledge.** There is no liability for nondisclosure of risks that are common knowledge or that the patient has previously experienced.

1-21. CONSENT IS NOT REQUIRED IN SOME EMERGENCIES

a. **Emergency Treatment.** Two conditions must be met in order to be able to treat an emergency patient without consent: 1) it must be a real emergency, and 2) it must be an emergency in which consent cannot be obtained.

b. **Real Emergency.** The patient's condition must be such that it requires immediate treatment, either to preserve life or prevent serious impairment.

c. **Consent Unobtainable.** It must be a situation in which it is impossible to obtain consent of any kind, either the patient's or someone else's. This means that the patient is mentally or physically unable to provide consent and there is no one available to provide authorized consent on the patient's behalf, such as a parent for a child.

d **Both Conditions Met.** If both of these conditions are met, then treatment may be provided, without consent and without risk of liability for battery. But, if one of the two conditions is not met (it is possible to obtain consent or it is not a real emergency), then the health care providers are limited in what they can legally do for the patient. If, for example, the patient has a wound, all that can be done is to clean it until consent is obtained.

1-22. CONSENT NOT REQUIRED FOR TESTS UNDER POLICE ORDER

Tests carried out under police direction for use as evidence in prosecuting suspected criminals do not require patient consent. Tests that the police might request include: breath analysis, urine analysis, blood samples, stomach pumping, and occasionally x-rays to detect swallowed contraband, such as diamonds or drugs. (The authority for tests used in ongoing investigations is based on constitutionally protected Fourth Amendment rights of probable-cause search.)

Continue with Exercises, Section III

EXERCISES, LESSON 1, SECTION III

It is recommended that you work the following exercises (1 through 11) before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response (a, b, c, or d) that **BEST** completes the statement or **BEST** answers the question.

1. The strictest interpretation of therapeutic privilege allows the physician to withhold information only if he or she believes that disclosure would cause the patient to:

   a. Forego treatment.
   b. Respond poorly to treatment.
   c. Become incompetent to consent to or refuse treatment.
   d. Incur physical, psychological, or emotional harm.

2. Under therapeutic privilege, the physician obtains:

   a. Blanket consent from the patient.
   b. Express consent from the patient based on limited disclosure of the relevant facts.
   c. Consent from the patient based on full disclosure.
   d. Freedom from the obligation to disclose any relevant information or to get patient consent.

3. When therapeutic privilege is exercised, most courts require that _____ who has been informed of all the relevant facts of treatment, concur with the patient's consent to the procedure.

   a. A relative.
   b. A chaplain.
   c. The court.
   d. Another physician.

4. An emergency patient can be given treatment without consent if immediate action is required to preserve life or prevent serious impairment and:

   a. Patient consent cannot be obtained.
   b. The next of kin is not available.
   c. The patient is unwilling to give consent.
   d. Consent of any kind is unobtainable.

5. An unconscious young man is brought to the emergency room with a deep cut in his foot. If an orthopedic surgeon does not perform surgery without delay, there will be permanent damage. The health care team can _____ without the risk of a malpractice suit.

   a. Only examine and clean the wound.
   b. Only examine and clean the wound, and prepare the patient for surgery.
   c. Perform the surgery.

6. The disclosure requirement may be waived for _____or when the physician must legitimately perform additional necessary procedures, without consent under the extension doctrine.

   a. An emergency.
   b. Minor surgery.
   c. A CAT scan.
   d. A biopsy.

7. If a patient does not wish to hear certain information relevant to treatment, the doctor should:

   a. Initiate a duly witnessed physician's waiver.
   b. Try to find an acceptable alternative method of getting the information to the patient.

   c. Feel free from any responsibility to disclose the information in question.

8. The police order stomach x-rays on a suspected thief who may have swallowed a stash of diamonds. In this situation, the radiologist:

   a. Must obtain consent from the patient unless he or she is competent.
   b. Must seek consent from a police official.
   c. Needs to obtain clearance from the patient's lawyer.
   d. Can proceed without obtaining consent.

9. The unconscious victim of a train wreck is brought into the emergency room. Her arm is irreparably mangled, and she will die unless it is amputated without delay. Consent cannot be obtained (the patient is not competent to give consent and there is no next of kin on hand). If the doctor operates, he or she:

   a. Will be liable for battery.
   b. Will have been acting within the law.
   c. May face administrative sanctions.
   d. Could be sued for negligence.

10. Therapeutic privilege **CANNOT** be exercised if the sole basis is a concern that the patient will:

    a. Respond poorly to treatment because of the information revealed.
    b. Incur physical, psychological, or emotional harm.
    c. Become incompetent to consent or refuse.
    d. Refuse treatment as a result of the disclosure.

11. Which of the following situations **DOES NOT** represent a legitimate basis for an exception to disclosure?

    a. The patient has already experienced the risk or knows about it.
    b. A resident recommends knee surgery without mentioning that a knee brace would be a viable alternative to surgery.
    c. Disclosure of all the pertinent information will jeopardize the success of a treatment.
    d. The patient was admitted under emergency conditions, and there was no time to disclose information or secure consent.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1, SECTION III

1. c (para 1-18e & figure 1-15)
2. b (para 1-18b)
3. a (para 1-18g)
4. d (para 1-21)
5. c (para 1-21)
6. a (para 1-19b & anecdote "Extension of Consent")
7. b (para 1-20a)
8. d (para 1-22)
9. b (para 1-21a)
10. d (para 1-18b)
11. b (para 1-18d, bottom and anecdote "Misuse of Therapeutic Privilege")

Go to Section IV

Section IV: DECISION MAKERS IN CONSENT SITUATIONS

1-23. CONSENT FOR ONESELF

a**. The Consent Giver**. As a general rule, consent for treatment must be obtained from competent adults and, in some states, emancipated and/or mature minors. Soldiers and military family members are also under this adult consent provision (with soldiers age 17 or older considered mature minors).

CONSENT FOR ONESELF

- Competent adult.
- Emancipated minor (some states).
- Mature minor (some states).

Figure 1-17. Consent for treatment is generally obtained from adults and, in some states, emancipated and/or mature minors, provided they are competent and capable of giving an informed consent.

b. **Competence.** Competence (or incompetence) is a legal determination made by a judge for any number of reasons, for example, competence to handle one's financial affairs, to make health care decisions. A competent adult is one who has not been declared incompetent by a court and who has adequate mental capacity (decision-making capability).

CRITERIA FOR COMPETENCE

The individual must have:

- An understanding of the information.
- An ability to communicate.
- A knowledge of the consequences of one's own decision(s).

Figure 1-18. A patient declared incompetent to handle his or her own financial matters might still be competent to make health care decisions.

competent (for consent purposes): having the mental capacity to understand information, to deliberate according to values, to weigh the consequences of one's own decisions, and to communicate one's wishes; a legal determination.

CHOOSING A MEDICALLY UNSOUND COURSE OF ACTION: THE SUBJECTIVE BEST INTEREST STANDARD

Choosing a medically unsound course of action that would lead to death does not demonstrate incompetence. In *Lane vs. Candura* (Mass., 1978), the court found a woman to be competent to refuse the amputation of her gangrenous leg even though her train of thought sometimes wandered, her sense of time was distorted, and she was confused on some matters. The court found that since the individual understood the alternatives and the consequences of her decision, she was competent to make her own health care decisions.

The law provides little guidance in defining competence for the purposes of consent, although there are some basic criteria. (See above.) No state statutes define the mental status required to consent to treatment, and there are few reported cases on which to base outcomes. The few cases available indicate that the courts are reluctant to deprive a patient the right to consent, to second-guess the patient's best interests, or to judge the appropriateness of the reasons for a patient's decisions. There are two standards for determining a patient's best interests: the objective and the subjective standards. (See figure below.) Under the objective standard, it is the *medically sound* course of action that is considered to be in the patient's best interests. Under the subjective standard, allowance is made for the patient who might choose another course of action. Choosing a medically unsound course of action may not be grounds for adjudicating incompetence, provided that the patient understands the available alternatives and their consequences.

PATIENT'S BEST INTEREST

OBJECTIVE STANDARD

If gangrene develops in the leg, it is in the patient's best interest to amputate the limb.

SUBJECTIVE STANDARD

The patient considering amputation is a dancer who cannot imagine life without dancing.

It is not in the patient's best interest, as she sees it, to opt for amputation of the limb.

Figure 1-19. The consent laws allow for both an objective and a subjective standard of the patient's best interests.

c. **If the Physician Has Doubts.** If the physician has doubts as to the patient's mental capacity, a consultation from another physician with the appropriate expertise should be obtained. It should be someone who is not treating the patient. If, for example, the physician suspects mental retardation, mental illness, or disorders that affect brain function, he or she can consult a psychiatrist or other appropriate specialists. If drugs or infection clouds the patient's judgment, an attempt should be made to remove the impediment to decision making. Such a patient is not considered incompetent, rather judgment is considered to be *temporarily impaired*.

TEMPORARY JUDGMENT-IMPAIRING CONDITIONS

- Drugs.
- Intoxication.
- Anxiety, depression.
- Unfamiliar hospital setting.
- Absence of supportive family.
- Anticipation of surgery.

PHYSICAL CONDITIONS ASSOCIATED WITH ALTERED MENTAL STATES.

- Infection.
- Metabolic disorders.
- Tumors.
- Trauma.
- Medication.
- Nutritional deficiencies.

Figure 1-20. If a temporary judgment-impairing condition exists and the patient's condition is not life-threatening, the physician must wait until the temporary condition is overcome before seeking the patient's consent for treatment.

1-24. INCOMPETENT ADULTS

a. **A Legal Determination.** Based on the physician's determination of mental incapacity, the judge will determine whether or not the patient is competent to give consent. The degree of understanding required in order for a patient to be declared competent will depend on the nature of the procedure to be performed, and the level of consent needed. As stated earlier, there are no clear guidelines defining competence apart from the ability to weigh alternatives. The determination of competence will ultimately depend on what satisfies the judge. (A person who is incapable of understanding alternatives is considered incompetent.)

> **incompetent (for consent purposes):** lacking the mental capacity to make rational decisions or to conduct one's personal affairs; a legal determination.

b. **Categories of Incompetence.** A person who is incompetent has impaired reasoning power. The individual lacks mental capacities, such as understanding, reasoning, and emotional stability. Such individuals lack sufficient mental capacity to appreciate the nature and consequences of their own decisions. There are a number of subcategories of incompetence that reflect the underlying cause of incompetence, i.e., the mentally ill, the mentally retarded, those with brain function disorders, the unconscious patient, and those adjudicated to be incompetent by a court for such purposes as making a contract or will, standing trial, being a parent, or giving consent.

c. **Competence in Other Areas Irrelevant.** The patient's competence to make other types of decisions (financial, business transactions, and so forth) is not relevant to the issue of competence for medical consent purposes. A patient found incompetent for other types of decision-making may still have the mental capacity to make health care decisions.

d. **Mental Capacity**. In day-to-day, bedside consent situations, it is the physician who makes the determination as to the patient's mental capacity (decision-making capability). Competence is *assumed* unless called into question by the physician's determination of mental incapacity.

mental capacity: the ability to make decisions and weigh alternatives; a clinical determination made by the physician.

COMPETENT PATIENTS

- Understand alternatives and the consequences of their own decisions.
- May be in a mental institution. (A medically irrational decision leading to death may be acceptable, if the above criteria are met.)

INCOMPETENT PATIENTS

- Mentally ill.
- Mentally retarded.
- Brain-function disordered.
- Unconscious.
- Mentally ill.
- Mentally retarded.
- Brain-function disordered.
- Unconscious.
- Adjudicated incompetent by a court.

Figure 1-21. What distinguishes a competent patient from an incompetent one is the ability to understand alternatives and the consequences of one's own decision(s).

In those cases in which the court is called upon to adjudicate competence for the purposes of consent, the judge relies on the physician's clinical assessment as to the patient's mental capacity as a point of reference.

e. **Temporarily Impaired Judgment.** As stated earlier, temporary conditions causing impaired judgment, that is, depression, anxiety, effects of medication, physical conditions causing altered mental states, etc., are not grounds for mental incapacity. The patient's judgment may be clouded, for example, by drugs or infection. If the patient's condition is not life threatening, the physician is obligated to help the patient overcome these conditions before providing the information needed to obtain informed consent.

f. **Medicolegal Decisions for Mentally Incapacitated Persons.** If the physician is convinced that the patient is mentally incapacitated, there are several options available. If the patient's condition is not life-threatening, the physician may hold off on treatment, and seek psychiatric or other help (chaplain, social services). If the condition is life-threatening, the physician may provide treatment based on implied consent and applicable state laws covering such patients, i.e., patients suffering from mental disease and those who are a danger to themselves or others. The physician or hospital administrator can seek authorization from the courts to treat the incapacitated person.

g. **Substitute Consent.** If a person is judged incompetent, a guardian is appointed to make decisions on the patient's behalf. The guardian's authority may be limited to a particular domain, such as business affairs, financial matters, or health care. (Laws concerning competence and guardianship vary by state.) When someone else has to provide substitute consent, the physician's responsibility to furnish all relevant information needed for decision-making is not eliminated. The surrogate decision maker (the legal guardian, the next of kin, or possibly the physician) acting on behalf of the patient is entitled to the same information that the patient would have needed to make an informed decision. Thus, the autonomy of the incompetent patient is, in some sense, preserved. A guardian, who has legal authority to make most of the decisions regarding the incompetent person's care, usually provides substitute consent. If there is no guardian assigned, then the representative of the incompetent adult, perhaps a close relative makes decisions concerning patient care. (Some patients with inadequate mental capacity have never been determined to be incompetent by a court, so they do not have guardians.)

SUBSTITUTE CONSENT IS AN INFORMED CONSENT INVOLVING

- Disclosure.
- Express consent.

Figure 1-22. A guardian with legal authority or a close relative who makes decisions on behalf of the incompetent patient usually gives substitute consent.

SUBSTITUTE CONSENT: FOLLOWING THE RULES DOESN'T ALWAYS MEAN THE BEST RESULT FOR THE PATIENT

Dr. Christine Castle, a prominent medical ethicist and chief of internal medicine at the University of Chicago Medical Center, believes that the application of ethical principles to health care in the last 10 years has helped resolve moral problems more equitably. At the same time, however, there are cases in which following the ethical rule hasn't always meant the best results for the patient. Dr. Castle cites a substitute consent case encountered by her own staff. The patient, a 78-year-old woman, was brought to the clinic for deteriorating mental function. Until that time, the woman had been relatively active, participating in senior center activities. She lived with her second husband, a man with failing health who was relatively housebound. Surprisingly, the woman was diagnosed as having syphilis. The mental symptoms associated with late syphilis had to be treated with penicillin. Following correct substitute consent procedure; the patient's daughter was advised of her mother's condition. The daughter, horrified to learn that her mother had a sexually transmitted disease, kept trying to imagine how she might have gotten it. Ultimately, she decided to place her mother in a nursing home rather than care for her in her own home, as she'd originally intended. Despite the best efforts of the health care team, the estrangement among daughter, patient, and spouse could not be resolved. And, in the end, the patient showed only slight improvement. The staff's concern as to how they might have better handled the case led to an article in a professional journal. The article generated 25 letters from physicians who, in confronting similar cases, had opted to give the elderly patient the medication without advising the family. Dr. Castle believes that these physicians transgressed the ethical principle because they were looking for the optimum results for their patients. And, she concludes that we may have to rearticulate some of the ethical principles or find new ways of solving problems, in some cases.[1]

1-25. CONSENT FOR/BY MINORS

a. **When the Parent's or the Guardian's Consent Is Needed.** State law governs local definitions as to who is a minor. Generally, consent of the parent or the guardian consent should be obtained before treatment is given to a minor. (Depending on the state, a minor may be someone under the age of 16, 17, or 18.) The consent of the parent or guardian is not needed in: 1) an emergency; 2) situations in which the consent of the minor is sufficient (some states allow minors to consent to receive birth control counseling and prescriptions or treatment for sexually transmitted diseases without parental knowledge); or 3) when a court order or other legal authorization is obtained (where the parents' personal beliefs stand in the way of treating a child for a life-threatening condition).

b. **Emergency Care.** Consent is implied in medical emergencies where there is an immediate threat to life or health, unless the health care provider has reason to believe that consent would be refused by the parent or guardian. In such a case, court authorization should be sought.

EXCEPTIONS TO PARENTAL CONSENT FOR MINORS

- An emergency (consent implied).
- When the consent of a minor is sufficient (emancipated/mature minors).
- Under court order.

Figure 1-23. Situations in which parental consent for a minor is not needed.

c. **Emancipated Minors.** Those who have assumed the life-style and responsibilities of adult status may consent to their own medical care. As a general rule, minors are emancipated when they are no longer subject to parental control or regulation, and are not supported by their parents. As a rule, a minor may be considered emancipated if he or she is married, a parent, or financially self-supporting and living away from home. The local Judge Advocate General (JAG) office can provide the specific rules for a given locale.

emancipated minor: a minor who has assumed the life-style and responsibilities of adult status and is not supported by either parent.

(1) Self-supporting minors living away from home can give consent for themselves.

(2) Married minors can give consent for themselves. If unable to give consent, the spouse may give consent. (But, in some states, the spouse must be an adult.)

(3) Minor parents may give consent for their children.

THREE TYPES OF EMANCIPATED MINOR

- Self-supporting and living away from home.
- Married minor.
- Minor parent.

Figure 1-24. Emancipated minors can give consent for themselves and their offspring.

Army policy is to follow state law as to when consent is not needed. The local JAG office should be consulted to determine the specific rule for a given location. If there is no applicable state or Federal law, Army policy is to seek the consent of the minor, giving special attention to the minor's maturity, age, and level of intelligence. Even in cases where the minor's consent alone is not legally sufficient, the minor's consent will be obtained along with that of the parent whenever the minor is able to understand the significance of a proposed procedure**.**

ARMY CONSENT POLICY

- Follows state law on exceptions to parental consent.
- Risks and alternatives are reviewed with mature, intelligent minor, even if parental consent is required.

Figure 1-25. The Army follows the local state laws on consent.

d. **Mature Minors.** In many states, mature minors (generally age 15 or older) may consent to some medical care because of minor treatment statutes empowering older minors to consent to medical treatment. The state law may allow the mature minor to consent, though not yet of age, based on such factors as the maturity of the minor, the nature of the procedure, and the benefit, if any, to the child. Many states have special laws concerning minor consent to sexually-transmitted disease and substance abuse treatment that have no age limits. Army policy, however, is to rely on the mature minor exception only as a last resort if the parents cannot be contacted. As a practical matter, whenever major medical treatment is proposed for a mature child, good medical and legal practice is to discuss with the child, as well as with the parents, the nature and purpose of the treatment, its risks, and any alternatives. In general, when treating any minor, parental involvement is to be encouraged. When a mature minor refuses to permit parental involvement, the provider can provide necessary care without substantial risk, unless there is likelihood of harm to the minor. When there is likelihood of such harm, it is advisable to involve the parents, unless state law specifically forbids parental notification.

MATURE MINOR LAW

MATURE MINOR LAW

- Permits consent by mature intelligent minors, in some cases.
- Applies generally to minors age 15 or older.

ARMY POLICY

- Consent by the mature minor as a last resort, if parents cannot be reached.

Figure 1-26. Mature minor laws exist in many jurisdictions.

TO WHAT EXTENT IS AN OLDER CHILD'S CONSENT NEEDED IN ADDITION TO A PARENT'S?

A question that is not currently dealt with in the law is the extent to which an older child's consent is required in addition to that of the parents. Can parents force a mature child to undergo treatment over his or her own objections? Lifesaving procedures can clearly be forced, but elective procedures are more problematic. It is good medical practice to discuss elements of disclosure with both the parents and the mature child. The state law may allow the mature minor to give consent, although not yet the age of majority based on such factors as: maturity, the nature of the procedure, and the benefit, if any, to the child. This generally applies to minors over age 15, but may also be applicable to those who are younger, based on the circumstances.

e. **Parental or Guardian Consent.** Either parent can give legally effective consent, except when there is legal separation or divorce. While it is not necessary to determine the wishes of the other parent, when it is known that the other parent objects, either the procedure should not be performed or court authorization should be obtained.

CONSENT FOR MINORS

CONSENT OF PARENT (GUARDIAN OR TEMPORARY CUSTODIAN)

- For minors underage 17*.

PARENTAL CONSENT NOT REQUIRED

- In an emergency.
- If a court order is obtained.
- For emancipated minors (married, a parent, or self-supporting and living away rom home).
- The Army follows the state law as to when parental consent is not needed.

CONDITIONS FOR MINOR CONSENT FOR ONESELF

- Age 18.
- Emancipated minor.
- Mature minor. (For the Army, a last resort if parents can’t be reached.)

*Under age 18 in some states and under 16 in others.

Figure 1-27. Army policy is to obtain the minor's consent even when parental consent is required.

f. **Babysitters.** Based on legal authorization or special power of attorney, a minor (or any other person) serving as temporary custodian of a minor may give consent for examination and treatment in an emergency.

1-26. CONSENT FROM OTHER THAN PATIENT

a. **Order of Substitute Consent.** When a patient cannot give consent, the next of kin may provide substitute consent. The general order of preference for such consent, which may vary slightly from state to state, is as follows: a spouse, a parent (for a child), an adult child (for a parent), an uncle, an aunt, and a grandparent. A JAG advisor can provide the order of preference for consent for the particular state in which you are practicing.

b. **Spousal Consent.** Spousal consent is needed if a married patient is unconscious or otherwise unable to consent. As stated earlier, it is also needed when a physician chooses to exercise therapeutic privilege, withholding information from the patient that may adversely affect treatment.

ORDER OF SUBSTITUTE CONSENT (GENERALLY)

- A spouse.
- A parent (for a child).
- An adult child (for a parent).
- An uncle.
- An aunt.
- A grandparent.

Figure 1-28. The order of consent may vary slightly by state.

Continue with Exercises, Section IV

EXERCISES, LESSON I, SECTION IV

It is recommended that you work the following exercises (1 through 20) before beginning the next lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MATCHING. For exercises **1 through 6,** match the term in the left-hand column with the appropriate definition in the right-hand column. Enter the appropriate letter in the space provided. (Note: There are two different definitions of an emancipated minor to identify, and there is an extra definition that will not be selected.)

_____ 1. Minor.	a. A minor who lives away from his or her parents and is self-supporting.
_____ 2. Mature minor.	b. Can give consent for his or her own child.
_____ 3. Minor parent.	c. Underage individual aged 16,17, or 18 depending on the state.
_____ 4. Emancipated minor.	d. A minor who is married or a parent.
_____ 5. Emancipated minor.	e. Automatically considered incompetent.
_____ 6. Good medical practice.	f. An older minor who can give consent in some states. For the Army, only a last resort if the parents can't be reached.
	g. Discussing medical alternatives with both parent and child.

MULTIPLE-CHOICE. Select the **ONE** response (a, b, c, or d) that **BEST** completes the statement or **BEST** answers the question.

7. Generally, consent to treatment for oneself is obtained from:

   a. Upstanding citizens and pillars of the community.
   b. Individuals with inadequate mental capacity.
   c. Competent adults and, in some states, emancipated and/or mature minors.
   d. Well-educated adults and minors.

8. A competent person is one:

   a. Who makes medically rational decisions.
   b. Who understands alternatives and the consequences of his or her own decisions.
   c. Who has an accurate conception of time and shows no signs of confusion.
   d. Whose train of thought does not wander.

9. If in doubt as to the patient's mental capacity, the physician should:

   a. Reevaluate the patient.
   b. Obtain affidavits regarding mental stability from the next of kin and the last physician who treated the patient.
   c. Exercise therapeutic privilege and obtain a patient waiver.
   d. Consult a psychiatrist or other appropriate specialist.

10. Substitute consent must involve:

    a. Disclosure and express consent by the patient.
    b. All immediate family members.
    c. Informed consent by a surrogate decision maker.
    d. A guardian or conservator with legal authority.

11. Parental consent is generally required:

    a. In an emergency.
    b. For emancipated and mature minors.
    c. When a court order designates a guardian.
    d. For minors.

12. Army policy regarding mature minors is to:

    a. Follow state law.
    b. Rely on the minor's consent only if the parents cannot be reached.
    c. Seek consent from minors who are age 15 or older.
    d. Use maturity, but not intelligence, as the criterion.

13 If the parents are divorced or separated, and it is known that one or the other parent objects to a procedure proposed for their child, either the procedure should not be done or:

a. A court authorization should be obtained.
b. Mature-minor rules should be applied.
c. The child should be treated as an emancipated minor.
d. A guardian should be appointed.

14. Mental capacity is generally determined by the:

a. Hospital ethics committee.
b. Courts.
c. Next of kin.
d. Physician.

15. It is advisable to involve parents in mature-minor decisions, especially when _____unless the state law expressly forbids it.

a. There is a likelihood of harm to the patient.
b. Substance abuse is involved.
c. Sexually transmitted diseases are diagnosed.
d. Dealing with the termination of pregnancies.

16. A married adult man, involved in an auto accident, is brought to the hospital in an unconscious state. Who would health care providers be most likely to call first to obtain substitute consent?

a. The patient's adult child.
b. His spouse.
c. His sister or brother.
d. His boss.

17. Which of the following individuals would **NOT** be considered incompetent for consent purposes?

a. A mentally ill, mentally retarded, or brain-function disordered patient.
b. An unconscious patient.
c. A drugged or intoxicated patient.
d. A patient who has been adjudicated incompetent for consent purposes.

18. Which of the following is **NOT** an emancipated minor?

a. A minor who is self-supporting and living away from his or her parents.
b. A mature 17-year-old.
c. A minor who is a parent.
d. A married minor.

19. Which of the following criteria is **NOT** applicable to mental incapacity for consent purposes?

a. It is a legal determination made by the judge.
b. The physician determines the decision-making capability of the patient at the bedside.
c. The judge relies on the physician's clinical assessment of mental capacity in adjudicating competence.
d. It refers to a condition that cannot be overcome.

20. Which of the following criteria is **NOT** applicable to situations in which the patient is suffering from temporarily impaired, good judgment?

a. The physician must help the patient overcome the condition causing impaired judgment if the patient's medical condition is not life-threatening.
b. Disclosure requirements still apply.
c. Depression, anxiety, intoxication, a drugged state, and certain medical physical conditions can cause impaired judgment.
d. It is the same as mental incapacity.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1, SECTION IV

1. c (para 1-25a)
2. f (para 1-25d)
3. b (para 1-25c)

4 -5. a and d, in any order (para 1-25c)

6. g (para 1-25d)
7. c (para 1-23a)
8. b (para 1-23b; figure 1-18)
9. d (para 1-23c)
10. c (para 1-24g)
11. d (para 1-25a)
12. b (para 1-25d)
13. a (para 1-25e)
14. d (para 1-23c)
15. a (para 1-25d)
16. b (para 1-26b)
17. c (paras 1-24b, 1-24e, & figure 1-21)
18. b (para 1-25c)
19. a (para 1-23c)
20. d (para 1-23c & figure 1-20)

NOTES

1. Patricia M. Danzon, "The 'Crisis' in Medical Malpractice: A Comparison of Trends in the United States, Canada, the United Kingdom and Australia," Law. Medicine & Health Care, Vol 18, pp 1-2, Spring-Summer 1990.

2. Dr. Christine Castle, "Ethics in Health Care," National Public Radio Broadcast, William Benton Broadcast Center, University of Chicago and Radio Smithsonian, July 15, 1991.

3. Ibid.

End of Lesson 1

LESSON ASSIGNMENT

LESSON 2	The Patient's Right to Refuse
LESSON ASSIGNMENT	Paragraphs 2-1 through 2-17
LESSON OBJECTIVES	Upon completion of this lesson, you should be able to identity (by selecting from alternatives):

2-1. The legal and ethical bases for the right to refuse treatment.

2-2. Situations in which competent adults may refuse treatment.

2-3. Situations in which refusal of treatment is possible, on behalf of incompetent adults and minors.

2-4. Situations in which the subjective (substituted judgment) standard is applicable.

2-5. Situations in which the objective best interests standard is applicable.

2-6. Refusal in an emergency.

2-7. Limitations on the patient’s right to refuse.

2-8. The role of a living will, an oral directive, and a Durable Power of Attorney for Health Care (DPAHC).

2-9. State interests that may override the patient’s right to refuse.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 1

THE PATIENT'S RIGHT TO REFUSE

Section I: THE RIGHT TO REFUSE TREATMENT

2-1. THE RIGHT TO CONSENT IMPLIES THE RIGHT TO REFUSE

a. **Adequate Mental Capacity.** An adult patient who is conscious and has adequate mental capacity has the right to refuse any medical or surgical procedure. Similarly, most courts have found that surrogate decision makers acting on behalf of incompetent adults and minors have the right to refuse, in appropriate situations. But, those making *decisions for others* have a *narrower range of choices*, because of the duty to act with the best interests of the patient in mind.

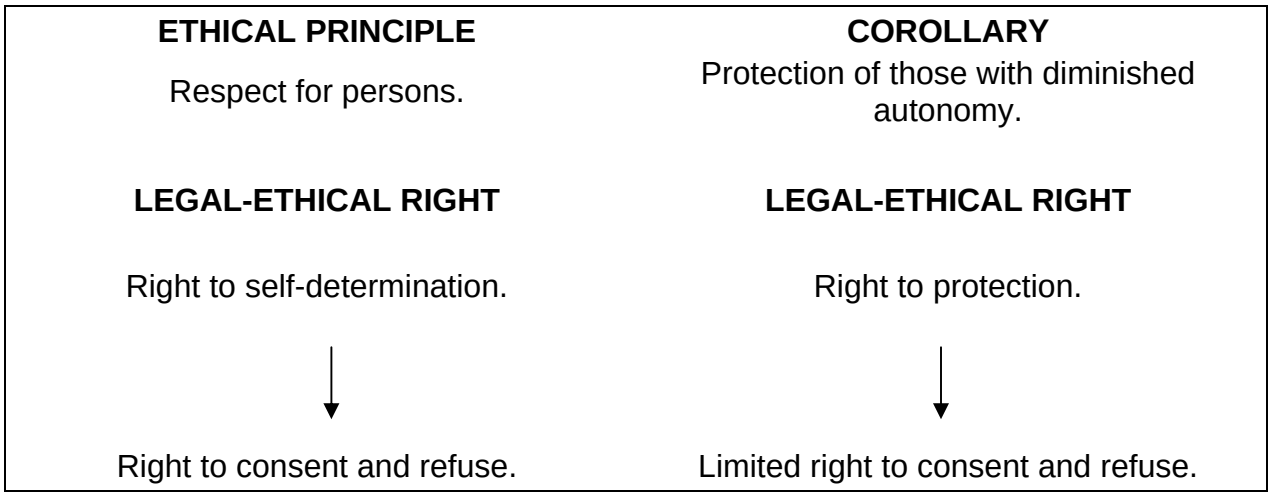


Figure 2-1. Those making decisions for children and incompetent adults have a more limited right to refuse treatment.

b. **Overriding State Interests**. While the right to refuse treatment is recognized in appropriate situations, the courts have found state interests to outweigh the patient's right to autonomy in some cases. The state must, however, show a *compelling overriding interest to overrule a patient's refusal*. The state's interest in promoting the welfare of children, for example, could justify an order for compulsory care to save the life of a pregnant woman or the mother of young children. When the patient's right to refuse is honored, however, the patient may have to forego other benefits. (See other column.) The legal bases for refusal of treatment include: 1) the common law right to freedom from nonconsensual (unauthorized) invasion of bodily integrity; 2) the constitutional rights of privacy and liberty; and 3) the constitutional right to freedom of religion.

IF THE RIGHT TO REFUSE IS HONORED, THE PATIENT MAY HAVE TO FOREGO CERTAIN BENEFITS

In *McQuillan vs. City of Sloux City* (lowa 1981), the court affirmed the denial of payment to a policeman for his continuing medical expenses. Since he had refused to submit to coronary arteriography that was necessary to diagnose his condition, he was not entitled to reimbursement.

THE RIGHT TO REFUSE BASED ON COMMON LAW BODILY INTEGRITY

In *re Storar** (N.Y.1981), the court recognized the right of Brother Fox, through his guardian, to decline respiratory support based on the common law principle of bodily integrity.

∗Latin for "in the matter of" Storar.

THE RIGHT TO PRIVACY AS THE BASIS FOR REFUSAL OF TREATMENT

Twenty-one-year-old Karen Ann Quinlan had become comatose as a result of a combination of alcohol and tranquilizers. She remained alive on a respirator, but was judged by physicians to be irreversibly comatose, with no reasonable possibility of emerging from her comatose condition. Her parents attempted to have the respirator that artificially sustained her breathing to be withdrawn. In *re Quinlan* (N.J. 1976), the right to privacy was recognized as the basis for honoring her parents' right to refuse treatment on her behalf. (Although the respirator was removed, Quinlan died 8 years later.)

REFUSAL BASED ON THE RIGHT TO PRIVACY

In *Lane vs. Candura* (Mass., 1978), the court honored a 77-year-old woman’s right to refuse the amputation of her gangrenous leg, based on the right to privacy. Although her decision was medically irrational and would lead to her death, the court found that she understood the alternatives and consequences of her actions. Thus, her right to privacy was upheld.

2-2. COMMON LAW-BODILY INTEGRITY

Common law recognizes the right of all people to be free from unauthorized invasion of their bodily integrity. One element of this right is the freedom to make decisions concerning medical care. Medical care without express or implied authority is battery. Courts have recognized that the right to make decisions concerning health care includes the right to decline such health care.

2-3. THE RIGHT TO PRIVACY

In some cases, medical care is refused on the basis of the constitutional right to privacy. *Unwanted infringements* of bodily integrity have been recognized to violate the right to privacy, unless state interests outweigh that right. In *re Quinlan* (N.J., 1976), the right to privacy was recognized as the basis for refusal to continue the life support system. The right to privacy has been the basis for allowing refusals in situations where the patient is neither terminally ill nor comatose. In the 1990 case of Nancy Cruzan, a young woman who had been in a persistent vegetative state for 7 years, the constitutional right to liberty was cited as the interest protected by the court, when they ruled that each state could set its own standards for allowing patient refusal.

2-4. FREEDOM OF RELIGION

Freedom of religion is another basis for refusal in a few situations. However, this First Amendment protection applies primarily to *freedom of belief, not* freedom of *action,* so the state may restrain religious action. Another reason that this freedom has limited relevance in refusal of treatment situations is because most religions merely *permit* refusal. Thus, legally required treatment does not necessarily violate religious tenets. The only cases in which freedom of religion has been pivotal have involved Jehovah's Witnesses' refusing blood transfusions or Christian Scientists' refusing all treatment. Although more recently, there have been a few cases pertaining to religious sects that believe in "faith healing," in which the right to refuse was upheld.

JEHOVAH'S WITNESS PERSPECTIVE

Refusing the blood transfusion.	vs.	Accepting the blood transfusion.
Eternal live without damnation.	vs.	Prolonged life on earth; eternal damnation in the hereafter.

HIGHER VALUE PLACED ON ETERNAL LIFE

PHYSICIAN'S PERSPECTIVE

Respect for the patient's autonomy.	vs.	The patient's objective best interest.
Respect for the patient's right to refuse.	vs.	Preserving and prolonging life.

HIGHER VALUE PLACED ON PROLONGED LIFE AND CURING DISEASE

Figure 2-2. Determining what is in the best interests of anyone other than oneself is difficult. In the case of a Jehovah's Witness, the best medical outcome is not the same as the outcome the patient might prefer. And the law, in some instances, recognizes the patient's right to refuse on religious grounds.

2-5. REFUSAL ON BEHALF OF A MINOR

Parental decision makers acting on behalf of minors have only a *limited right to refuse*, because of their overriding obligation to act in the best interests of the child. If a parent refuses necessary treatment, the courts will intervene and appoint a guardian who will give consent. The court considers the age and maturity of the minor and the risk-benefit factors of the treatment, in determining what weight to give the wishes of the minor. The prerogative to decline is limited to treatment that is *elective or not likely to be beneficial.* Courts have generally permitted the refusal of extraordinary care for terminally ill or irreversibly comatose minors and incompetent adults.

When acting on behalf of a minor, the surrogate decision-maker must:

- Act in the best interests of the child.
- Consent to necessary treatment.

Figure 2-3. Surrogate decision makers have a limited right to refuse treatment for minors.

INCOMPETENT TERMINAL PATIENT'S RIGHT TO REFUSE UPHELD IN ONE CASE, OVERRIDDEN IN ANOTHER

In *Superintendent of Belchertown vs. Salkewicz* (Mass. 1977), the court authorized the withholding of chemotherapy for 67-year old Joseph Salkewicz, a profoundly retarded man. It was felt that he would not have understood the pain resulting from chemotherapy, and would have had to be held down physically for doctors to give him the necessary drugs and blood transfusions. The court summed up its decision as follows. "To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality," it is of interest to note that, like John Storar, Salkewicz was a mentally retarded person who had never been competent. Yet, in the Storar case (held 4 years later in New York) the court did not allow the terminally ill and incompetent Storar patient to refuse blood transfusions. Observes medical ethicist Ruth Macklin; "Cases that are apparently similar may be decided differently in different jurisdictions."[1] This highlights a point made earlier: In many cases, the courts have as much difficulty making morally equitable decisions as any of us. They too must apply an array of often-conflicting values. There may seem, on the face of it, some differences between the Salkewicz and Storar cases with regard to type of treatment: extraordinary treatment (chemotherapy) vs. routine therapy (blood transfusion, almost as basic as food itself). Says Macklin: "...other factors have a greater moral significance [than the type of treatment, that is, mode of dying ...peaceful and easy vs. painful and frightening."[2]

2-6. REFUSAL FOR AN INCOMPETENT ADULT

a. **More Steps in Honoring the Right to Refuse.** When the patient cannot express his or her wishes, important decisions are left up to the family members, doctors, hospital administrators, and if conflict should arise, a court of law. An incompetent adult who was previously competent has the right to refuse treatment. The rules are generally stricter for a never competent patient because of the impossibility of determining his or her wishes. (See anecdote, page 2-7, on John Storar, a never-competent patient.) Because of the state's duty to protect those with limited autonomy, more steps are involved before refusal can be authorized. These additional steps are intended as safeguards to protect the patient from a decision that might not be in his or her own best interests.

b. **Subjective (Substituted Judgment) Standard.** Under the subjective standard, the *patient's definition* of "best interests" is sought, rather than some objective standard. Thus, maximum deference is given to the patient's right to self-determination, even if the decision is not objectively in the patient's best interest. The subjective (substituted judgment) standard can only be applied if there is some evidence of what the patient would have wanted. Prior oral or written directives are the best evidence of the patient's desires. Though oral directives have been accepted by some courts, a written directive, i.e. a living will and Durable Power of Attorney for Health Care (DPAHC) (where applicable by state law), are easier to substantiate than an oral directive.

SUBJECTIVE (SUBSTITUTED JUDGMENT) STANDARD

- Determining what the patient would have wanted.
- Using evidence of patient's prior wishes. Oral directives are preferable to written directives.

Figure 2-4. Under the subjective (substituted judgment) standard, maximum allowance is given for the patient's right to self-determination, even if refusal is not *objectively in* the patient's best interests.

c. **The Objective Best Interests Standard.** The best interests standard generally requires the surrogate (next of kin, legal guardian, and so forth) to consider such factors as relief of suffering, preservation or restoration of function, and the quality and extent of the sustained life *as viewed* by *the patient.* The quality-of-life component tries to determine the value of the patient's life *to the patient*, and does not measure the value of life according to the patient's ability to contribute to or produce in society. If a surrogate were to refuse beneficial treatment for no justifiable reason, that decision would be seriously questioned.

OBJECTIVE BEST INTERESTS STANDARD

The surrogate determines the incompetent patient's best interests by considering:

- Relief of suffering
- Preservation and/or restoration of function.
- Quality and extent of sustained life (as viewed by patient).

NOTE: The individual's value to society is not a factor.

Figure 2-5. Under the objective best interests standard, the surrogate decides whether refusal is in the best interests of the patient by considering the factors shown. The patient's wishes and his or her value to society are not considered.

RISK-BENEFIT ANALYSIS

- Extent of impairment of patient's mental faculties.
- Whether or not patient is in the custody of the state.
- Prognosis with and without treatment.
- Complexity, risk, and novelty of treatment.
- Possible side effects.
- Patient's level of understanding and probable reaction.
- Urgency of the decision.
- Consent of patient, spouse, or guardian.
- Good faith of those participating in the decision.
- Clarity of professional opinion as to what is good medical practice.
- The interests of third persons.
- Administrative requirements of the institution (different in each hospital).

Figure 2-6. A risk-benefit analysis may have more of a role to play for a never-competent patient whose wishes are unknown. It may also be useful as an aid to parents making decisions for minors.

SUBJECTIVE (SUBSTITUTED JUDGMENT) STANDARD APPLIED: PREVIOUSLY COMPETENT PATIENT'S WISHES HONORED

In *re Storar* (N.Y. 1981), the subjective (substituted judgment) standard was applied. The court upheld the right of the previously competent but now comatose patient, Brother Fox, to refuse treatment based on an oral statement he had made to his religious brethren. Shortly before suffering a cardiac arrest, becoming comatose, and being placed on a respirator, he had told his brethren that he would not want to be kept alive by "extraordinary means," were he to become like Karen Ann Quinlan (irreversibly comatose but kept alive by a respirator). The New York State Court of Appeals authorized removal of the respirator, since they considered his oral statement to be "clear and convincing" evidence of his prior wishes.

OBJECTIVE BEST INTERESTS STANDARD APPLIED: RIGHTS TO REFUSE DENIED NEVER COMPETENT PATIENT

The same court* denied a never competent patient the right to refuse treatment because his wishes could not be determined. In the absence of expressed wishes, the objective standard had to be applied. John Storar, a 52-year-old man who was profoundly retarded (with a mental age of about 18 months) was suffering from terminal cancer of the bladder. His legal guardian and mother had consented to radiation treatments for him and, after internal bleeding had begun, regular blood transfusions. She then requested that her son's transfusions he terminated, because he was suffering from both the pain of his cancer and the discomfort of being tied down for transfusions. And, it was estimated that the transfusions would only add 3 to 6 months to his life. Unlike a respirator, which is considered "extraordinary" treatment, blood transfusions are viewed as routine (as basic as food itself). Unlike Brother Fox, Storar had never been competent. The court ruled that since the patient was mentally an infant, he should be given the same protections as a minor whose guardian seeks to refuse life-saving transfusions. The decision, which seems cruel, was well-intentioned in that it sought to protect a patient, who could not speak for himself, from relatives acting contrary to what was *believed* to be the patient's best interests.

The court decided both Brother Fox's and John Storar's cases in an opinion entitled *re Storar*.

2-7. CRITERIA TO CONSIDER FOR INCOMPETENT ADULTS

a. **Written Document or Living Will.** Forty-four states have enacted "living will" statutes. These are written directives by the patient for use in making health care choices in the event that the patient should become incompetent. Having a living will is no guarantee that a patient's advance directives will be followed. A recent study of 175 nursing home residents found that in about 25 percent of the cases, the patient's instructions were *not* followed. The Army recognizes living wills and complies with them where possible. But, the existence of such a will does not really change the attending physician's responsibility to determine that the patient, in fact, meets the requirements for withdrawal of life support. What the living will does is to *provide evidence of the patient's previously stated desires while* he or she was *competent* to do so. If the family does not wish the living will to be honored, the matter should be referred to the hospital ethics committee.

LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Says Doron Weber, spokesperson for the National Council on Death and Dying and the Society for the Right to Die, "The Supreme Court essentially gave *constitutional stature to living wills*," by its decision in the Cruzan case (emphasis added).[5] There has been increased public interest in drawing up a living will since that decision, because it enables you (while your are still competent) to specify which treatments you would or would not want if you became irreversibly incapacitated and dependent on life-sustaining treatment. The guidance that you provide will increase the likelihood that your wishes are honored. It will also help your family get through some tough decisions. Some living will forms simply refuse all "heroic" treatment. But, it is best to *list specific procedures* you would or would not want such as: cardiac resuscitation (Do Not Resuscitate [DNR] order), withdrawal of life-sustaining treatment (a mechanical respirator or a feeding tube). You can specify conditions, for example, withdrawal of life support for a terminal condition, permanent vegetative state, or irreversible brain damage that makes one unable to swallow, cessation of circulatory and respiratory functions (traditional definition of death), or cessation of all functions of the entire brain, including the brain stem. You can ask for painkillers or request to die at home. Though living wills are not legally binding, 44 states have "right-to-die' laws, and often recognize living wills as good evidence of intent (needed to apply the subjective standard of refusal for incompetent adults). In some states, like New York and California, a living will should be supported by a Durable Power of Attorney for Health Care. This legally binding document enables the person you designate and a backup (people who presumably understand your wishes) to make health care decisions for you should you become incompetent.[6] In Texas, the Natural Death Directive is needed to supplement the living will and ensure the legal right to die.[7]

A LIVING WILL MAY NOT BE ENOUGH IN AN EMERGENCY

A retired Los Angeles bus driver, suffering from lung cancer, drew up a living will to avoid life-sustaining technology that would prolong his life and suffering. Then one morning, while preparing breakfast, he felt a sudden intense pain in his back and cried out. Paramedics, called on the scene by his wife, began a massive resuscitation effort when they found no pulse. (They passed a line in a vein in his arm and a tube through his mouth into his lungs.) A DNR order in the living will did *not* hold, because *living wills do not apply during emergencies that are in or out of the hospital.* (Emergency teams are required to act first, lest crucial time to save a person's life be lost. This is what the bus driver's daughter was told when she complained that her dad had a living will specifying no massive resuscitation.) The paramedics rushed the man to the hospital, Emergency room staff drew a blood sample, attached wires and hooked him up to a respirator, and sent him to an intensive care unit, where he remained unconscious with a prognosis of continued unconsciousness until death. The doctor agreed not to provide further aggressive care, but did not feel he could disconnect the respirator. Despite the living will, despite the fact that medical ethicists draw *no ethical distinction between discontinuing existing treatment and starting new treatment*, the doctors own values got in the way. Though California courts have allowed respirators to be turned off in such cases, the only thing the doctor could offer was to have the hospital ethicist review the case. Five more days lapsed before the ethics consultation concluded, and the man was taken off the respirator. In this case, if the patient's daughter had had a Durable Power of Attorney for Health Care, she would have been able to make medical decisions for her father as if she were making them for herself.[8] A Durable Power of Attorney for Health Care in combination with a living will may be a more effective means of increasing the chances that one's health care wishes will be followed.

b**. Oral Directives.** Written evidence is preferable to oral directives conferred to a family member, friend, or health care provider. Brother Fox's verbal statements to brethren regarding his desire to avoid heroic treatment were accepted as clear and convincing evidence of his wishes. (See anecdote, p 2-7, "Subjective (Substituted Judgment) Standard Applied....") But in *Cruzan* vs. *State of Missouri* (1990), the Supreme Court denied Nancy Cruzan's family the right to terminate life-support equipment for their daughter, who had been in an irreversible coma for 7 years, for lack of "clear and convincing"[4] evidence defining the patient's wishes. Statements by friends and family did not hold up as "clear and convincing" in the state of Missouri. (The Supreme Court later upheld each state's right to develop its own standards for clear and convincing evidence.) Granting someone power of attorney gives that individual the instrument of authority to act on your behalf. Historically, once a person became incapacitated, the power lapsed. To overcome this limitation, all states have passed

legislation allowing a power of attorney to be "durable," that is, enduring even if the maker's competency doesn't last. To create a *Durable* Power of Attorney for Health Care, the instrument must merely state that it is intended to be durable, or that the power created will not be affected by the incapacity of the maker. Durable-power-of-attorney laws vary by state, with some states allowing Durable Power of Attorneys for Health Care to cover health care decisions. (The person designated as primary and backup should, of course, have a full understanding of the patient's desires.) Some states with DPAHC laws may allow agents to be named to make medical treatment decisions, to include withdrawal of life-sustaining treatment. Other states do not include decisions for withdrawal of treatment. Still other states have durable-power-of-attorney laws that do not address medical treatment decisions at all.

c. **Durable Power of Attorney for Health Care.** Since there is only one state court decision in this area (from New Jersey), there is an insufficient basis for anticipating how the courts will interpret the use of a Durable Power of Attorney for Health Care. For example, it is not known whether or not the "Do Not Resuscitate (DNR)" decision made by the holder of a power of attorney for an incapacitated patient would be upheld, especially if there were no other indication of what the patient would have wanted. In principle, a Durable Power of Attorney for Health Care would be effective in a military treatment facility (MTF) under the reasoning expressed, above, for living wills. In any case, a DPAHC (where applicable) may increase the likelihood that one's living will be honored.

d. **Preparing Advance Directives that Carry Clout.** To ensure that the living will is as effective as possible, you should. 1) specify applicable conditions and treatments, 2) renew the document at least every 2 years, and 3) in the states where applicable, have a DPAHC drawn up, as well.

(1) Be specific. The living will should be as specific as possible in citing the conditions for which the patient does not wish heroic treatment and the types of interventions not desired, for example, respirator, feeding tube, and so forth.

(2) Renew every two years. The document would be renewed every two years. Physicians are apt to disregard a living will if it is several years old, or if it fails to specify the particular condition that you happen to develop.

(3) Have a Durable Power of Attorney for Health Care if applicable. Having a DPAHC, if applicable in your state, increases the likelihood of compliance with your living will.

DO HEALTH PROVIDERS HAVE LIVING WILLS?

Dr. Christine Castle. Medical Ethicist and Chief of Internal Medicine at the University of Chicago Medical Center observes that although 44 states recognize living wills, *few people* exercise their option to *prepare advance directives*. This is true, *even among health care providers*. Dr. Castle remarks that in any given audience of doctors and nurses that she addresses, invariably *no more than ten percent* raise their hand when asked it they have a living will. She concludes from this telling fact that "there is something fundamentally human about not wanting to think about one's own death."[9]

PATIENT SELF-DETERMINATION ACT of 1991

Currently, only 5 to 10 percent of all adults have advance directives. The Patient Self-Determination Act of 1991 encourages more patients to think ahead by requiring every hospital, hospice, nursing home, and health-maintenance organization participating in Medicare and Medicaid to inform patients of their right to decide how they want to live or die should they become gravely ill. Each state has to develop its own laws on advance directives. Each hospital, in turn, has to make that information available to its patients upon admission. At the present time, medical treatment facilities are not covered, however, this does not preclude a future requirement for them to comply with these guidelines. [10]

e. **Deduced From Religious Beliefs.** An oral directive might play a role for patients expressing opposition to treatment on religious grounds. The refusal of care could be deduced from the patient's statements of religious beliefs, *provided these beliefs were sincerely held and practiced while the patient was competent*. (On the other hand, religious beliefs might not play a role. An individual might not agree with all of the teachings of his or her own faith. Some Jehovah's Witnesses, for example, will accept a blood transfusion if convinced they would die without one.)

f. **Condition, Prognosis, and Nature of the Treatment.** Generally, if the patient's condition is extremely grave, some courts have permitted refusal of any type of treatment.

g. **Risk-Benefit Analysis.** If there is no knowledge of what the patient's wishes were, as in the case of a never-competent patient, a risk-benefit analysis will have a greater role to play in arriving at a treatment decision. (A risk-benefit analysis may also be helpful to parents trying to make a decision regarding treatment for a minor.)

h. **Degree of Consensus Between the Surrogate and Physician.** The court attaches great weight to what the treating physician has to say about the surrogate's decision. If the surrogate's decision is consistent with good medical practice, the court is more likely to honor refusal of treatment. The court attaches great weight to the physician's opinion because the physician is the person most familiar with the patient's condition. The physician has had previous experience in making this type of decision, and he or she is, in principle, less apt to be acting out of self-interest or bias.

i. **Nature of the Surrogate's Relation to the Patient.** This is the least important of the factors. But it still plays a role when the court decides to uphold a decision that goes beyond medical custom and practice, as in the case of Karen Quinlan. The court looks for a close loving relationship. Any evidence of conflicting motivations or special interests will affect the credibility of the surrogate's decision.

2-8. DO NOT RESUSCITATE ORDER

a. **A Written do not resuscitate Order Required.** Resuscitation is a *standing* order that will be initiated unless there is a written Do Not Resuscitate (DNR) order. The DNR order is a written order to suspend otherwise automatic initiation of cardiopulmonary resuscitation (CPR). The *only treatment suspended is CPR*. The DNR order is not a withdrawal of life support and should not affect other treatment and efforts to provide comfort and relief from pain. A DNR order is in writing and must be reviewed every 72 hours.

> **Do Not Resuscitate (DNR) order:** a written order to suspend otherwise automatic initiation of cardiopulmonary resuscitation (CPR).

b. **Candidates for a Do Not Resuscitate Order.** Potential candidates for a DNR order are irreversibly, terminally ill patients and those in a persistent vegetative state.

> **irreversible terminal illness:** a progressive disease or illness known to terminate in death, and for which additional therapy offers no reasonable expectation of remission.
>
> **persistent vegetative state:** a chronic state of diminished consciousness resulting from severe generalized brain injury, in which there is no reasonable possibility of improvement to a cognitive *(*perceiving and knowing) state.

c. **Competent Patients Make Own Choices.** As stated earlier, under state laws competent patients are adults or emancipated minors, who have the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved. A decision made while the patient is competent will be honored if subsequent incompetence occurs, *unless there is reason to believe that the patient's choice has changed or would change*. This sometimes happens when living wills are so generally worded that there is doubt as to whether or not certain specific medical conditions are covered by the will. Questions may also arise if time has elapsed since the initial drafting of the will.

THE COMPETENT PATIENT'S REFUSAL PREVAILS OVER FAMILY'S WISHES

Mrs. Jones, a 45-year-old wife and mother suffering from the advanced stages of terminal leukemia, was nearing death. She was tired of the normal and experimental treatments she had undergone over the preceding year. The only thing she wanted now was to be made comfortable and sleepy. On the hospital admission form, she refused all further routine treatment and supportive measures (antibiotics, blood transfusions, and so forth). She also indicated that she did not wish to be resuscitated in the event of cardiac arrest. The physician complied, ordering only an IV morphine drip "until the patient becomes lethargic." But, Mrs. Jones' husband and child, unwilling to let go and still hoping for a miracle, demanded continued aggressive treatment. (Does the family have the right to overrule the patient's refusal? No. *As long as the patient is competent the patient remains the primary health care decision maker*). Once the patient lapsed into unconsciousness, the physician continued to comply. This is as it should be. To begin aggressive treatment once the patient had become unconscious would have violated the respect-for-persons principle.[11]

d. **Confidential Do Not Resuscitate Orders.** If the patient chooses not to inform his or her family of the DNR decision, the patient should be made aware of the problems that can result. If, for example, the family should demand resuscitation, the physician would then be placed in the difficult position of having to deal with the family's demands, while still trying to honor the patient's desire for confidentiality.

e. **Surrogate Do Not Resuscitate Orders.** When no prior decision has been made and the patient is incompetent, the next of kin (generally the spouse or competent adult child) may choose to exercise the DNR option for the patient.

DNR ORDER

- Without a DNR order, CPR is obligatory.
- Written.
- Reviewed every 72 hours.
- Affects CPR only. Other treatments continue.
- Can be made confidential by the patient.

Figure 2-7. A Do Not Resuscitate order suspends the otherwise automatic initiation of CPR.

f. **When No Next of Kin or Guardian.** When there is no next of kin or guardian and the physician feels that a DNR order is appropriate, the matter may be referred to the Deputy Commander of Clinical Services (DCSS) and the ethics committee for decision and approval. The ethics committee, by regulation, should consist of at least two physicians, a nurse, a chaplain, and a Judge Advocate officer. (The panel can also resolve conflicts between the physician and family members regarding the appropriateness of a DNR order. If there is still no agreement between the surrogate decision maker and the staff after the ethics committee has reviewed the case, it will then go to court.)

IS SUBSTITUTED JUDGMENT A LEGAL FICTION?

Dr. Christine Castle, Medical Ethicist and Chief of Internal Medicine at the University of Chicago Medical Center, believes that living wills are not the real solution to the problem of preserving the autonomy of incompetent patients. The appointed decision makers must decide what the patient would have wanted in a given situation. Most of the judgments that the guardian or next of kin must make involve complex emotional relationships. It is, she contends, hard to sort out one's own feelings from what the patient would have wanted. She believes that the courts are realizing that substituted judgment is, in fact, a legal fiction, that we cannot really place ourselves in the shoes of another.[12] But admittedly, at the present time we do not have a better alternative.

2-9. WITHDRAWAL OF LIFE SUPPORT

a. **Criteria for Withdrawal of Life Support.** Patients with a terminal condition or those in a persistent vegetative state (irreversible coma) are candidates for withdrawal of life support.

b. **Treatment That Artificially Prolongs Life**. Life-sustaining treatment that serves only to *artificially* prolongs life such as: intravenous therapies (artificial nutrition and hydration), lavage feedings (nasogastric tube), kidney dialysis, CPR, and artificial respiration may be withdrawn in the event of a terminal condition.

> **life-sustaining treatment:** any medical procedure or intervention which serves only to artificially prolong the dying of a patient, diagnosed and certified by at least two physicians as afflicted with a terminal condition or as being in a persistent or chronic vegetative state.

It should be noted that medical interventions necessary to alleviate pain are not considered life sustaining.

c. **The Physician's Decision.** While a living will may *request* that life-sustaining procedures be withheld or withdrawn under certain conditions, it is only *the physician* who can determine whether or not the patient meets the *criteria* for withdrawal of life support. The order for withdrawal of life support is written with the concurrence of the patient or, in the case of incompetent patients, with the concurrence of the next of kin or surrogate decision maker. If the next of kin does not wish the living will to be honored, the matter should be referred to the hospital ethics committee.

d. **Brain Death Not a Criterion.** The traditional clinical definition of death is not required for life support to be withdrawn. Once brain death has occurred, there is no legal obligation to continue treatment.

> **brain death:** the irreversible cessation of circulatory and respiratory functions or of all functions of the entire brain, including the brain stem.

2-10. REFUSAL IN AN EMERGENCY

a. **Competent Patients Refusing Emergency Care**. Normally, in an emergency, treatment can be given without obtaining prior consent and without fear of liability if there is a threat of serious bodily harm or death. However, if a *competent* patient refuses treatment in an emergency, the normal emergency rule waiving consent requirements does not apply. For example, the police alert an ambulance to the scene of an auto accident. The ambulance picks up a person who is unconscious. By the time the ambulance reaches the emergency room, the patient is conscious and raises objections to treatment. This person cannot be treated even though it is an emergency. Nor can the physician, in this case, wait until the patient's condition worsens or until the patient lapses into unconsciousness to commence treatment.

b. **Refusal as a Possible Sign of Incompetence.** Health care providers are required to respect a competent patient's right to refuse treatment, even in an emergency. But providers have an equal responsibility to identify cases in which *irrational* self-destruction is contemplated by the patient. In these instances, refusal of care may be a sign of incompetence. Let us imagine that a patient is brought to the emergency room with slashed wrists and says that he or she does not wish to live or be treated. It cannot *automatically* be assumed that the patient really wishes to die. Bioethicists hold that the slashed wrists may be a cry for help. In such cases, treatment should be provided under implied consent, until such time as the patient's competence and consent can be ascertained. Only after the patient is revived and the situation is talked through can a determination be made as to the patient's true needs and desires. If, at that point, the patient still wishes no further treatment, the physician has a moral obligation to seek help for the patient.

Continue with Exercises, Section 1

EXERCISES, LESSON 2, SECTION I

It is recommended that you work the following exercises (1 through 28) before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response (a, b, c, or d) that **BEST** completes the statement or **BEST** answers the question.

1. Compared to competent adults refusing treatment for themselves, those making decisions on behalf of incompetent adults and minors have _____right to refuse because of their duty to act in the best interests of the patient.

   a. A greater.
   b. A more limited.
   c. The same.
   d. No.

2. In which case would the State be likely to overrule the patient's right to refuse treatment, based on a compelling and overriding state interest?

   a. Extraordinary care for a terminally ill minor.
   b. Extraordinary care for a comatose incompetent adult.
   c. Life-saving care for a young child.
   d. Life-saving care for a Christian Scientist (a competent, single adult).

3. Those making decisions for minors and incompetent adults can generally decline:

   a. Any treatment they deem inappropriate.
   b. Treatment that is elective or not likely to be beneficial.
   c. Any treatment that they would refuse if making a health care decision for themselves.

4. A mentally retarded, 18-year-old male is brought to the emergency room. he has attempted suicide by taking an overdose of sleeping pills. He flails his arms about, and threatens to sue the hospital if his stomach is pumped. The health care team should:

   a. Explain the consequences of no treatment and have him sign a patient waiver.
   b. Comply with his wishes.
   c. Begin treatment right away.
   d. Obtain a bedside consultation from the hospital ethics committee.

5. A competent 18-year-old female is admitted to the emergency room for rectal bleeding. The injury is the result of an accident and is not an attempted suicide. the patient refuses the proposed treatment with a full understanding of the consequences. The staff should:

   a. Try to force her to consent.
   b. Get a court order declaring her incompetent, and obtain substitute consent from a surrogate decision maker.
   c. Sedate her; then begin the treatment.
   d. Comply with her wishes.

6. In which instance would the state's interest in preserving life be most likely to outweigh the patient's right to refuse treatment?

   a. A schizophrenic who refuses a biopsy with apparent understanding of the adverse consequences.
   b. A minor suffering from terminal leukemia that refuses chemotherapy.
   c. A competent adult who refuses to have his gangrenous arm amputated.
   d. An incompetent adult who would benefit from treatment, who has left no evidence of his or her wishes when competent.

7. Under the subjective (substituted judgment) standard of a patient's best interests, maximum deference is given to:

   a. The patient's right to self-determination.
   b. The integrity of the health care profession.
   c. The *res ipsa loquitur* doctrine.
   d. The state's interest in public welfare and safety.

8. Under the subjective (substituted judgment) standard of a patient's best interests:

   a. Some evidence of the patient's prior wishes is needed.
   b. The family's wishes are given primacy.
   c. Maximum deference is given to the needs of the institution.
   d. The individual's value to society is considered.

9. In which situation is the patient's right to refuse most likely to be *overridden* by the state's interest in preserving life?

   a. A terminally ill minor who is in agreement with parents and physician on refusing further treatment.
   b. A terminally ill and competent adult who refuses surgery.
   c. An incompetent patient whose guardian refuses beneficialmedical intervention for no justifiable reason.
   d. A competent adult who refuses treatment in an emergency room.

10. A pregnant woman refuses care that might affect the life of the fetus. What is the likely outcome?

    a. The court might override her refusal for the sake of the fetus.
    b. The court might override her refusal for both her sake and the sake of the fetus.
    c. The court would respect her right to self-determination because it is her body.
    d. The court would declare her incompetent, and have her institutionalized for the course of the pregnancy.

11. A competent adult has a living will that specifies that she does not want extraordinary or heroic treatment (resuscitation) in the event that she should suffer a massive heart attack. She also has a Durable Power of Attorney for Health Care drawn up. Nine months later she has a heart attack and lapses into an irreversible coma. She is likely to be:

    a. Placed on a respirator.
    b. Allowed to die without extraordinary resuscitative efforts being applied.
    c. Placed on a respirator until the hospital ethics committee can make a determination.
    d. Be treated for lack of sufficient evidence of her prior wishes.

12. A living will is a written directive concerning health care choices that:

    a. Guarantees one's wishes will be honored if one becomes incompetent.
    b. Is legally binding.
    c. Gives clear and convincing evidence of a patient's previously stated desires while competent.
    d. Is required by law for all individuals,

13. Army policy on living wills is to:

    a. Comply in all cases.
    b. Comply, if the physician determines that the patient meets the requirements for withdrawal of life support.
    c. Comply, even if the next of kin voices opposition.
    d. Refer all living will situations to the hospital ethics committee.

14. For states with durable-power-of-attorney laws, having a Durable Power of Attorney for Health Care, together with a _____ may increase the likelihood that one's health care wishes are honored.

    a. General power of attorney.
    b. Last will and testament.
    c. Bequest to the hospital.
    d. Living will.

15. An incompetent patient's _____when sincerely held and practiced while competent, may be considered, in some cases, as evidence of the patient's wishes regarding treatment.

    a. Religious beliefs.
    b. Personal affiliations.
    c. Attitude toward work.
    d. Political convictions.

16. When evaluating refusal of treatment for a never competent patient, the court may consider.

    a. The patient's past contributions to society.
    b. The patient's potential value to society.
    c. Risk-benefit factors associated with the proposed procedure.

17. One factor that holds a great deal of weight with the court is whether or not a physician finds the surrogate's decision to refuse care to be:

    a. Cost-effective.
    b. Consistent with good medical practice.
    c. Unbiased.
    d. Merciful.

18. The least important factor to the court in assessing refusal of care for incompetent patients is:

    a. The patient's religious beliefs.
    b. A living will.
    c. The nature of a surrogate's relationship to the patient.
    d. A Durable Power of Attorney for Health Care.
    e. Oral directives to family, friends, and health care providers.

19. What does a Do Not Resuscitate (DNR) order mean?

    a. It triggers cardiopulmonary resuscitation (CPR).
    b. It is a withdrawal of life support.
    c. It suspends the otherwise automatic initiation of CPR.
    d. It permits the withdrawal of a respirator.

20. The next of kin can choose the DNR option for:

    a. A competent patient.
    b. An incompetent patient who made no indication of his or her wishes while competent.
    c. An incompetent patient with a living will, specifying his or her wishes regarding a DNR order.
    d. A patient who makes his or her DNR request confidential.

21. A DNR order must be in writing and reviewed every _____ hours.

a. 24.
b. 48.
c. 72.
d. 96.

22. A patient with _____may be a candidate for withdrawal of life support.

a. A terminal condition or in a persistent vegetative state.
b. Cessation of all functions of the circulatory and respiratory functions.
c. Irreversible cessation of all functions of the entire brain, including the brain stem.

23. A determination that the criteria for withdrawal of life support are met is generally made by consulting the:

a. Living will.
b. Next of kin.
c. Ethics committee.
d. Physician.

24. In some states, the patient's preferences regarding withdrawal of life support may be expressed in a:

a. Living will combined with a Durable Power of Attorney for Health Care.
b. Last will and testament.
c. Regular nondurable power of attorney.
d. Written consent form.

25. Which of the following is **NOT** considered a life-sustaining procedure that artificially prolongs life?

a. Intravenous therapies.
b. Lavage feedings (nasogastric tube).
c. Medical intervention to alleviate pain.
d. A respirator.

26. Which is **NOT** the basis for the right to refuse?

a. The freedom of assembly amendment.
b. Common law bodily integrity.
c. The right of privacy or liberty.
d. The freedom of a religion amendment.

27. Which is **NOT** a factor for consideration in determining the best interests of an incompetent patient, under the objective best interests standard?

a. Relief of suffering.
b. Preservation or restoration of function,
c. Quality and extent of life sustained (as viewed by the patient).
d. Ability to contribute to society.

28. Which is **NOT** a requirement for a Do Not Resuscitate (DNR) order?

a. Brain death.
b. Irreversible terminal illness.
c. A persistent vegetative state.
d. An irreversibly comatose state.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 2, SECTION I

1. b (para 2-1a & figure 2-1)
2. c (para 2-1b)
3. b (para 2-5)
4. c (para 2-10b)
5. d (para 2-10a)
6. d (para 2-6c)
7. a (para 2-6b & caption, figure 2-4)
8. a (para 2-6b)
9. c (paras 2-6c & 2-1b)
10. a (para 2-1b)
11. b (para 2-7d)
12. c (para 2-7a)
13. b (para 2-7a)
14. d (para 2-7c)
15. a (para 2-7e)
16. c (para 2-7g)
17. b (para 2-7h)
18. c (para 2-7i)
19. c (para 2-8a)
20. b (para 2-8e)
21. c (para 2-8a)
22. a (para 2-9a)
23. d (para 2-9c)

24. a (para 2-7c)

25. c (para 2-9b)

26. a (paras 2-2 thru 2-4, para titles)

27. d (para 2-6c)

28. a (para 2-9d & 2-8b)

Go to Section II

Section II: LIMITS ON THE RIGHT TO REFUSE

2-11. STATE INTERESTS

There are four state interests that have been recognized by courts throughout the country. These state interests may outweigh the individual's right to autonomy in health care decision-making, and thus, the patient's right to refuse treatment. (See chart below.)

STATE INTERESTS THAT MAY OUTWEIGH A PATIENT'S RIGHT TO REFUSE TREATMENT

1. Preserving the sanctity of all life.

   Particular patients involved in a given action (especially patients with life-threatening conditions, minors, and dependents).

2. Protecting innocent third parties who may be adversely affected by the death of a party seeking relief.

3. Preventing suicide.

4. Preserving the integrity of the medical profession.

   NEW STATE INTEREST

5. "Encouraging the charitable and humane care of those whose lives may be artificially extended under conditions which have the prospect of providing at least a modicum of quality living."*

*Nevada Supreme Court decision (1991), binding in Nevada; could affect other courts faced with similar situations.

2-12. THE SANCTITY OF LIFE: PATIENT AUTONOMY OVER STATE INTERESTS

a. **Incompetent Patient Who Is Terminally Ill or Irreversibly Comatose.** The sanctity of life is the most basic of the state interests. It overrides the right to refuse medical care in a number of cases. However, the principle of autonomy, also a basic concept of health care ethics in the United States (US), has led courts to recognize wishes expressed in living wills and other advance directives for patients who are incompetent and terminally ill, or irreversibly comatose (in a persistent vegetative state).

INFORMING A COMPETENT, NONTERMINAL PATIENT OF ALL OPTIONS FOR ALTERNATIVE CARE

Kenneth Bergstedt, a 31-year-old quadriplegic, injured at age 10 as a result of a swimming accident, had been ventilator-dependent and entirely reliant on others for his bodily functions for over 20 years. His limited entertainment (reading, watching television, and writing poetry with a computer) also required the attentive care of others. With his mother's recent death (1978) and his father approaching death, "he despaired over the prospect of life without the attentive care, companionship, and love of his devoted father." He also felt uneasy about care at the hands of strangers and the prospect of an agonizing death should the ventilator malfunction.[13]

A lower Nevada court ruled that Bergstedt's constitutional privacy right to discontinue further medical treatment outweighed each of the state's four state interests. But, the Nevada State Supreme Court went on to identify a *fifth state interest* for competent non-terminal patient: "..[to] encourage the charitable and humane care of those whose lives may be artificially extended under conditions which have the prospect of providing at least a modicum of quality living.[14] M. Rose Gasner, Staff Attorney for the New York-based Society for the Right to Die, observes: "courts seem to have a problem understanding the choice of someone who does not have a terminal illness and does not want to live on life support"[15]

Gasner concludes that the Nevada decision may have been affected by past cases like that of Larry McAfee, a competent, non-terminal quadriplegic who, after winning the right to discontinue ventilator treatment, opted to live when offered a more pleasant and productive alternative to his existing lifestyle. The McAfee case showed that "patients may not know everything that is available [and that] ...not enough effort [has been made] to provide rehabilitation services." The intent of this additional state interest is to ensure that competent, disabled people have knowledge of all the services and support that are available. In this way, the right to die would only be entertained after a close scrutiny of all the alternatives.

THE COURT UPHOLDS THE RIGHT TO REFUSE LIFE-SUSTAINING DEVICES FOR NONTERMINAL, INCOMPETENT PATIENT SUFFERING FROM DEGENERATIVE DISEASE

In *re Claire C. Conroy* (Supreme Court. N.J., 1985), Claire Conroy, an 84-year-old, nursing-home resident who was not comatose, was permitted to have life-sustaining devices withdrawn, although she had no written living will and the treatment involved food and fluids rather than extraordinary treatment.

Mrs. Conroy was suffering from severe and irreversible arteriosclerotic heart disease, hypertension, diabetes, incontinence, mental impairment, and she could not swallow food and water. Her nephew requested that the nasogastric tube extending from her nose to her stomach be removed. He based this request on knowledge of his aunt's beliefs and the testimony of a Catholic priest regarding church doctrine on euthanasia. The court ruled that withdrawal of life-sustaining treatment was warranted since there was evidence that the patient would have refused treatment. Furthermore, the burdens of treatment (continued suffering) outweighed the benefits (a few months more of life with a limited capacity to enjoy life and loved ones).

b. **Competent Patient Who Is Not Terminally Ill.** When the patient is not terminally ill, courts have declined to order treatment when the intervention is major, such as the amputation of a gangrenous limb. However, there is some controversy when a rational person, who is still competent and neither terminally ill nor in a persistent vegetative state, chooses death over life.

PATIENT REFUSAL GENERALLY PREVAILS FOR:

- Terminally ill (competent, incompetent, minor).
- Major intervention (competent patient).

STATE INTEREST IN LIFE GENERALLY PREVAILS FOR:

- Curable minors.
- Curable incompetent adults.

Figure 2-8. The state interest in preserving life generally prevails when protecting the interests of non-terminal minors and incompetent adults with curable conditions.

For example, a quadriplegic or an individual suffering from amyotrophic lateral sclerosis (ALS), better known as Lou Gehrig's disease. The Nevada court (previous chart,

para 2-11) was concerned that the individual, not knowing the full range of possible options, might think that his or her only choices were death or a lower quality of life.

c. **Life-Saving Treatment for Minors and Incompetent Patients**. When the patient is a minor or incompetent, courts are more likely to authorize even major life-saving interventions, unless the patient is terminally ill or irreversibly comatose. Courts will authorize some treatments for pregnant women to preserve the life of the fetus, immediately before and during birth.

d. **Overriding a Patient's Refusal of Care When the Patient is in Pain.** When a patient refuses care because of pain and discomfort, the patient's ability to determine his or her own best interests is put into question. In such circumstances, the court allows the physician to operate somewhat paternalistically (in an authoritative, "a father who knows best," manner). The physician cannot simply respect the patient's wishes when pain may be obscuring judgment. The spouse and/or family are asked to communicate the urgency of the situation to the patient. (See the Dax Cowart case, below.)

DAX COWART, ATTORNEY AND BURN VICTIM, MAINTAINS THAT BURN VICTIMS ARE COMPETENT TO KNOW IF PAIN IS TOLERABLE OR NOT

In 1978, Dax Cowart suffered critical burns in a propane-gas explosion near Henderson, Texas. The pain was so excruciating that he begged a passing farmer for a gun with which to kill himself. En route to the hospital, he implored the medic to let him die. For more than a year, and against his will, he went through extremely painful treatments. His right eye and several fingers were removed; his left eye was sewn shut. He was in constant pain and kept demanding that treatment be stopped. One night, he crawled out of bed to try to throw himself out of a window, but was discovered and prevented. Although Cowart was able to piece together a new life after the accident (married and a law school graduate, he is living in Texas and managing his investments), he remains adamant in the conviction that physicians violated his right to refuse treatment. He regularly addresses ethics groups to get his message across. "It doesn't take a genius to know that when you're in that amount of pain, you can either bear it or you can't. And I couldn't," says Cowart.[17] (Doctors were following standard guidance that patients in great pain are not competent to make judgments.) But contends Cowart, the patient's rights are compromised in a no-win situation. When the patient initially refuses care "...it's the pain talking. And then when narcotics are given to subdue the pain, they say it's the narcotics talking."[18] In Cowart's case, doctors acted paternalistically (in an authoritarian, "father knows best" manner). They overruled his pleas in the belief that he would one day recover sufficiently to be grateful. Health care ethics classes often view a film depicting Cowart's injury, excruciating treatment, and recovery when considering the state interest in the sanctity of life versus a patient's right to autonomy.

RIGHT TO REFUSE OVERRIDDEN, THEN UPHELD FOR YOUNG, COMPETENT NONTERMINAL PATIENT

In *Bouvia vs. County of Riverside* (Calif., 1983), the court was faced with what to do about a young, non-terminal competent patient who wished to refuse food and hydration. The patient, a 26-year-old woman, had suffered from cerebral palsy from birth. Although severely disabled, she was not terminal. Ms. Bouvia was in a great dea of physical pain and increasingly unhappy with the dehumanizing aspects of having a permanent tube through her nose and into her stomach. Convinced that her life was hopeless, she sought to starve herself to death while hospitalized. When the hospital attempted to force-feed her, she went to court in an attempt to obtain an injunction that would stop the forced feeding, arguing that her constitutional right to privacy permitted her to starve herself to death.

The court disagreed. It held that while the patient might have the right to end her life, she did not have the right to do so with the help of the hospital staff. Thus, Ms. Bouvia' right to privacy was outweighed by society's interest in preserving her life and in protecting against the adverse effect her decision would have upon the professional integrity of those caring for her and upon other patients in the hospital.

However, in 1986, the California Court of Appeals overturned the original decision in a unanimous vote. They concluded that not "all and every life must be preserved against the will of the sufferer."[19] The court added "the right to refuse medical treatment" was "basic and fundamental."[20]

Upon winning her case, however, Bouvia decided not to have the feeding tube removed. Susan M. Wolf, J.D., an associate for law at the Hastings Center, a medical ethics think tank in Briarcliff Manor, N.Y., says that the Bouvia case is a "prime example of the paradoxical nature of competent, non-terminal patients and the right-to-die. It is proper that the courts stand ready to vindicate the right. Whether a person chooses to exercise it is a quite separate right." [21]

2-13. PRESERVING THE SANCTITY OF ALL LIFE: PUBLIC SAFETY AND WELFARE

a. **Ethical Responsibility.** The state has an interest in protecting the public safety and welfare. The public safety is an exception to what is normally done for the patient in terms of protecting a patient's autonomy, confidentiality, and privacy. There is an ethical responsibility imposed upon physicians to protect and promote the public safety, which, at times, may compromise the welfare of the individual patients. In such situations, when there is a genuine risk to specific persons or to the public at large, the physician must take measures to protect the public safety at the expense of the patient's interests. The quarantining of carriers of infection, mandatory immunizations, and the reporting of infectious diseases to the health department are public safety measures required by law, in most jurisdictions. These measures are designed to warn, for

example, the spouse of a person who has been tested HIV-positive, and to provide preventive therapeutic measures to persons other than the patient. Violent threats by a patient to do bodily harm to others is another situation that may necessitate a recommendation for involuntary detention or tranquilizing when there is a serious intent to do harm.

WHICH SITUATION WARRANTS PLACING THE PUBLIC SAFETY ABOVE THE INDIVIDUAL PATIENT'S RIGHTS?

SITUATION 1:

You are treating a boy for a case of measles. He is not suffering great discomfort or itching. The child's mother seems intent on sending her son back to his school and day care center, although the boy is still highly contagious. In this case, you are obliged to inform the school and day care center that this child is highly contagious, that others may have already been exposed, and that additional cases my be expected if the child returns. There is a *genuine threat* to the child's classmates, so the public safety prevails.

SITUATION 2:

A dialysis technician working in a kidney dialysis unit is hepatitis B-antigen positive. The technician seeks advice from her personal physician regarding this disease, which can be transmitted sexually or by exposure to blood. She expresses a reluctance to inform family and friends or limit professional activities. In this case, there is *no significant threat*, as *infectivity is low*. In addition, kidney dialysis patients are routinely immunized. Therefore, the technician's interests take precedence over the public safety. The physician should counsel the patient about using universal precautions and taking special care to protect patients from exposure to her blood. But, there is no need to report the technician to her superior (If there were a high risk of infection, there might be an obligation to report the incident to the health care provider's superior.) The technician should, however, receive counseling on her personal life and the use of proper sexual precautions. The decision to abstain, limit herself to mutual monogamy (one sexual partner), or practice safe sex is her prerogative. The patient's rights prevail because the disease is not easily contagious.

SITUATION 3:

A school board seeks input on a proposal to routinely test all of its teachers for the HIV-I antibody test to prevent the spread of AIDS. In this case, health officials should not support the school board because a blanket infringement on the liberty and privacy of such a large population would be unwarranted. There is *no realistic threat*, since AIDS is not transmitted through casual contact. What's more, such testing would yield false positives. Additionally, a positive antibody finding does not necessarily mean that full-blown AIDS will develop. The harm to the teachers' reputations, employability, and insurability would be substantial and unwarranted, when there is no genuine threat.

b. **Legal Requirements.** In most localities, there are laws requiring the physician to report sexually transmitted diseases, gunshot and knife wounds, and spousal and child abuse. When there is clear evidence that the reportable condition exists, the physician should obey the statute. Exceptions should not be taken lightly. The states vary on reporting requirements for HIV-positive cases.* Some states have no laws on HIV-positive, some require the simple reporting that an incident has occurred, others require a case number, and still others require the name of the patient for the purpose of contact-tracing the sexual partners of the individual.

NOTE: All states require the reporting of full-blown AIDS cases.

2-14. PRESERVING THE SANCTITY OF ALL LIFE: MINORS AND INCOMPETENT ADULTS

As stated earlier, decision makers acting on behalf of minors and incompetent individuals have a more *limited right to refuse*, because of their overriding obligation to act in the best interests of the patient. The courts generally authorize Major surgery/treatment, such as removal of gangrenous limbs, surgical treatment of an infant's hydrocephaloid condition to prevent mental retardation, and chemotherapy, for minors and incompetent persons. When parents or guardians are not following reputable medical advice, courts authorize treatment that is likely to be beneficial for life-threatening conditions, for example, chemotherapy for a child with leukemia. When parents have refused treatment, for example, blood transfusions on religious grounds, the courts have generally authorized such treatment when the minor had a life-threatening condition and was not terminally ill.

2-15. PROTECTING INNOCENT THIRD PARTIES (DEPENDENTS)

When an adult with responsibility for the care of minor children and other dependents refuses treatment that would probably restore the adult to normal functioning, the state may intercede. Thus, the state asserts an interest in *protecting minors and other dependents from the emotional and financial damage of the patient's refusal*. This has come up in cases in which Jehovah's Witness patients with children have refused transfusions. The state may authorize a transfusion in such cases, because of the individual's responsibility for dependents.

2-16. IRRATIONAL SELF-DESTRUCTION

Courts have generally recognized that there can be a competent rational decision to refuse treatment when the treatment involves substantial risk or death is imminent. There are also many court decisions in which it was decided that the patient could do whatever he or she wanted so long as the individual in question was competent and there was no third party (minor or dependent) being adversely affected. In an emergency, however, when the patient's competence cannot be immediately assessed, a physician should treat the patient under implied consent. (See para 2-10.)

PUBLIC SAFETY: OBLIGATORY VACCINATION

In *Jacobs* vs. *Massachusetts* (Supreme Court, 1905), the court upheld the right of the state to require an adult to submit to a vaccination to help prevent the spread of disease.

PATIENT REFUSES TREATMENT, HAVING MADE PROVISIONS FOR HIS CHILDREN

In *re Osborne* (Wash., D.C., 1972), the court refused to authorize a transfusion for a father of two minor children because he had made adequate arrangements for their future well-being.

DO PARENTS HAVE THE ABSOLUTE RIGHT TO REFUSE TREATMENT FOR THEIR MINOR CHILDREN?

According to *Prince* vs. *Massachusetts* (Supreme Court, 1944), "parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." There is a trend toward weakening of parental authority when it conflicts with generally accepted medical practice. Every court, which has considered this question, has concluded that parents may not refuse treatment if the result would be the death of a child with an otherwise good prognosis. This is true even if the refusal is based on the parents' religious beliefs. The decision maker has an obligation to act in the best interests of the child (the ethical principle of beneficence) and, therefore, must consent to necessary treatment. Thus, if a parent refuses to consent to necessary treatment for a child, the courts are generally willing to intervene and appoint a guardian who will provide consent. Most states have laws, which protect abused or neglected minors. Parents who refuse to allow medical treatment for their children are considered to be neglectful.

2-17. THE ETHICAL INTEGRITY OF THE HEALTH CARE PROFESSION

The state interest in maintaining the ethical integrity of the profession means that hospitals should have the opportunity to care for patients that have been admitted, *no matter what the wishes of the patient*.

> **ethical integrity of the health care profession:** the medical profession's right to act affirmatively to save lives without fear of civil liability.

Consider the case of Ms. Bouvia, a competent, non-terminal young woman, suffering from cerebral palsy, who refused forced feeding. The court initially ruled that her right to privacy was outweighed by society's interest in preserving her life and in preserving the ethical integrity of the profession. Some courts have found that the patient's right to privacy is superior to professional and institutional concerns. Other courts have concluded that honoring the wishes of the patient or the patient's representative is consistent with health care ethics, so there is no conflict between professional integrity and honoring the patient's wishes.

SEXUALLY TRANSMITTED DISEASE TREATMENT FOR PROSTITUTES

In *Reynolds vs. McNichols* (Colorado,1973), the court upheld a Denver ordinance requiring prostitutes to accept treatment for sexually transmitted diseases (STDs).

Continue with Exercises for Section II

EXERCISES, LESSON 2, SECTION II

It is recommended that you work the following exercises (1 through 10) before beginning the next lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response (a, b, c, or d) that **BEST** completes the statement or **BEST** answers the question.

1. Which patient's right to refuse is most likely to be overridden by the state interest in preserving life?

   a. A terminally ill incompetent patient whose guardian refuses further treatment on the patient's behalf.
   b. A terminally ill, competent adult who doesn't want surgery.
   c. An infant whose parents refuse major medical intervention required to prevent mental retardation.
   d. A competent adult who refuses the amputation of a gangrenous arm.

2. A pregnant woman needs immediate care. She refuses treatment although it might affect the life of the fetus. The court would probably:

   a. Override her refusal for the sake of the fetus.
   b. Disregard the rights of the fetus and honor her refusal.
   c. Respect her right to autonomy over her own body.
   d. Seek a review by the ethics committee.

3. A burn victim refuses treatment because he cannot tolerate the excruciating pain that the treatment only intensifies. The hospital is likely to:

   a. Let the patient forego treatment, since there is a point at which the quality of life becomes more important than the length of one's life.
   b. Proceed with treatment because the pain is affecting his ability to understand his own best interests.
   c. Seek the consent of the patient's next of kin before proceeding.
   d. Give the patient strong painkillers and then seek his consent.

4. A Jehovah's Witness with two dependent children refuses a blood transfusion for himself. This individual has made no provision for the care of these children in the event of his death. The court will probably:

   a. Authorize an alternative treatment.
   b. Make the children wards of the state and obtain a written release from the patient.
   c. Respect the patient's right to religious freedom, but make the children-wards of the state.
   d. Authorize treatment in the interests of the children.

5. In which case is the patient's right to refuse likely *to be overridden* by the state interest in preserving life?

   a. A faith healer who refuses to have his broken leg set.
   b. An incompetent, irreversibly comatose patient whose surrogate decision maker refuses heroic treatment on the patient's behalf.
   c. A competent adult who refuses a vaccination for a contagious disease.
   d. Parents who refuse treatment for their terminally ill child who has no hope of recovery.

6. Which patient's wish to refuse treatment is likely to present the most controversy?

   a. A non-terminal, competent quadriplegic who refuses food and water.
   b. A terminally ill, incompetent patient with advance directives, whose next of kin refuses heroic treatment.
   c. A terminally ill minor whose parents refuse treatment on his behalf.
   d. A patient in a persistent vegetative state whose next of kin wishes to follow the patient's living will directives to forego a respirator.

7. Under the state interest of _____health care providers have the right to act affirmatively to save lives without fear of civil liability.

   a. The sanctity of life.
   b. Protecting innocent third parties.
   c. The public safety and welfare.
   d. The ethical integrity of the profession.

8. When there is a *genuine* threat to third parties or the public-at-large, the physician's obligation to protect the individual patient's interests:

   a. Remains the same.
   b. Is subordinated to the public safety and welfare.
   c. Is entirely eliminated.
   d. Is assessed by the American Medical Association.

9. Which of the following is **NOT** a public safety situation in which state interests prevail over the rights of the individual patent?

   a. Reporting a child abuse case.
   b. Reporting a gunshot of knife wound.
   c. Recommending mandatory immunization against an infectious disease.
   d. Recommending the quarantine of carriers of infection.
   e. Recommending treatment or detention of a patient with a serious intent to do bodily harm to another individual.
   f. Supporting a school board's proposal to require HIV-I antibody testing for all teachers to prevent the spread of Acquired Immune Deficiency Syndrome (AIDS).

10. Which of the following has **NOT** been formally recognized as a state interest that could limit the patient's right to refuse treatment in all states?

    a. Preserving the sanctity of all life.
    b. Protecting innocent third parties who may be affected by a patient's refusal of treatment.
    c. Preventing irrational self-destruction.
    d. Preserving the ethical integrity of health care providers.
    e. Ensuring that non-terminal patients are aware of all health care and lifestyle alternatives.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 2, SECTION II

1. c (2-12c)

2. a (2-12c)

3. b (2-12d)

4. d (2-15)

5. c (2-13a)

6. a (2-12b)

7. d (2-17)

8. b (para 2-13)

9. f (para 2-12, para 2-13 anecdote, same page: "Which Situation Warrants Placing the Public Safety Above the Individual Patient's Rights?")

10. e (para 2-11, chart: item 5)

NOTES

1. Ruth Macklin, Mortal Choices, Pantheon Books, N.Y., 1987, pp 50-54.

2. Ibid.

3. "Life and Death Issue: Medical Officials Grappling with New Living Will Requirement, "San Antonio Express -News, July 26, 1991, p 13-A.

4. "The Right to Pull the Plug," San Antonio Express News, July 20, 1990, p 6-B.

5. Ibid., p 6-B.

6. "Why You Need a Living Will," University of California at Berkeley Wellness Letter, Vol 6, Issue 6, pp 1-2, March 1990.

7. "The Right to Pull the Plug," p 6-B.

8. M. Wilkes, M.D. and M. Shuchman, M.D., "Is a Living Will Enough?" L.A. Times Magazine, pp 33 & 38, March 4, 1990.

9. Christine Castle, M.D., "Ethics in Health Care," National Public Radio Broadcast, The William Benton Broadcast Center, The University of Chicago, Radio Smithsonian, July 15, 1991.

10. "Life and Death Issue: Medical Officials Grappling with New Living Will Requirement."

11. Macklin, p 77.

12. Castle.

13. "New State Interest Defined for Competent, Nonterminal Patients," Medical Ethics Advisor, p 50, April 1991.

14. Ibid.

15. Ibid., p 51.

16. Ibid.

17. Nancy Gibbs, "Love and Let Die," Times Magazine, p 65, March 19, 1990.

18. Ibid.

19. "Decision Reversed," Time Magazine, p 78, April 28, 1986.

20. Marcia Chambers, "Patient Wins Morphine Plea...," The New York Times, p 24, May 23, 1986.

21. "New State Interest Defined for Competent, Non-terminal Patients," p 49.

End of Lesson 2

LESSON ASSIGNMENT

LESSON 3	Privacy, Confidentiality, and Medical Records
LESSON ASSIGNMENT	Paragraphs 3-1 through 3-18
LESSON OBJECTIVES	Upon completion of this lesson, you should be able to identity (by selecting from alternatives):

3-1. The definition of a medical record.

3-2. The contents of the clinical and administrative records.

3-3. The purpose of a medical record.

3-4. Ownership of and access to medical records.

3-5. The definition and purpose of privacy.

3-6. Limitations on the right to privacy.

3-7. The definition of a privileged communication.

3-8. Situations in which confidentiality applies.

3-9. The elements of the triangle of confidence and its legitimate extensions.

3-10. Situations in which state interests may override the right to confidentiality.

3-11. Information that should be documented in the radiology department.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

Section I: THE PHYSICAL RECORDS

3-1. MEDICAL RECORD DEFINED

A medical record is a document (military or civilian) that provides information on patient evaluation, findings, diagnosis, and/or treatment.

medical record: a document that outlines patient evaluation, findings, diagnosis, and/or treatment.

3-2. THE PURPOSE OF A MEDICAL RECORD

a. **Planning and Continuity of Treatment.** The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a civilian organization that reviews and accredits all military and civilian hospitals, defines the purpose of the medical record. According to the JCAHO, the medical record is intended to serve as the basis for planning patient care. The medical record provides for continuity in the evaluation of the patient's condition and treatment. If a patient gets sick repeatedly, health care providers can look back at what happened the last time and/or how the patient reacted to medication. If a patient breaks his or her leg more than once, the first set of radiographs can be compared to the second set.

b. **Documentation.** A medical record provides documentary evidence. It describes the course of the patient's medical evaluation and treatment. It provides a record of any changes in condition. (A change in condition might be profuse bleeding from a laceration, which is subsequently stabilized upon stitching.) The medical record reflects changes in a patient's condition that may occur in the hospital, as an outpatient (ambulatory care), during an emergency hospital visit, or in a hospital administered home care program. (Military hospitals do not commonly get involved in home care. For long-term illnesses, home care is less costly than admission into a hospital facility.) A civilian nurse providing home care would keep track of the patient's pulse, medication, and so forth.

c. **An Efficient Means of Communication for Health Care Providers.** A medical record documents communication between responsible practitioners and any other health care professionals responsible for the patient's care. For example, consider an x-ray technologist who takes radiographs and initials the number of films taken. By making these entries, the radiographer is not only documenting his or her actions, but also communicating with the physician. The physician does not have to walk over and talk to the radiographer about every patient he or she sees. It would be inefficient and time-consuming to do so. Thus, the record provides an efficient means of communication.

d. **Protection of Legal Rights.** The medical record is a legally valid source of accurate information on the patient, the responsible practitioner, and the hospital. As such, it can be used to protect the legal rights of the parties involved.

e. **Data Source.** The medical record is a useful source of data for continuing education programs and research. For example, the number of cases of spinal meningitis reported in 1949, the symptoms reported, and the treatment provided can be determined by a quick review of the medical records. Of course, all names would have to be deleted from information extracted from the medical records to protect the patients' privacy.

3-3. CHARACTERISTICS OF A MEDICAL RECORD

Since medical records serve so many important purposes, they have to constitute a complete, accurate, and up-to-date record of the patient's history, condition, and treatment. The health care provider may, at times, view the record-keeping aspect of the job as a nuisance; so much paperwork that detracts from the main mission--that of caring for the patient. But, medical records serve so many important functions that they *cannot* be taken lightly by the health care provider who is charged with making accurate and timely entries. One adverse consequence of faulty record-keeping relates to insurance reimbursement. If a hospital or physician fails to maintain complete and accurate medical records reflecting the treatment rendered, it may not be possible to obtain third-party reimbursement under MEDICARE, MEDICAID, and private insurance coverage.

3-4. COMPONENTS OF A MEDICAL RECORD

a. **Admissions Record.** The first part of the medical record, the admissions record, is compiled when the patient is first admitted to the hospital. The admissions record includes the patient's name, age, reason for admission, and any other pertinent information on the patient's history.

b**. The Clinical Record.** The second part of the medical record is the patient's clinical or treatment record. It should provide a continuing history of the treatment provided and the patient's physical history. The exact nature of the complaint (the reason for which the patient sought care) should be specified. There should be a temperature chart, an admitting diagnosis and a subsequent diagnosis. (A patient admitted for one complaint, might be revealed to have an entirely different diagnosis after further testing or he or she might undergo a change in condition.) Consultations should be included in the clinical record. The military "Consultation Sheet" should accompany the patient as part of the patient's medical record when he or she is referred to such places as orthopedics. Medical notes, medications, laboratory results, and x-ray readings are additional components of clinical record. Surgical or delivery (birth) records are also an important feature of the record. These should include anesthesia reports and/or operative procedures and findings. Nursing notes, which list blood pressure, temperature, and so forth, are another feature of the record. One-page summaries of everything that has happened for the whole of the patient's hospital stay are yet another important component of the record. The conditions of the patient at the time of discharge and/or autopsy findings, if any, are also part of the record.

COMPONENTS OF A MEDICAL RECORD

I. **Admissions Record.**

- Patient's name and age.
- Reason for admission.
- Pertinent medical history.

II. **Clinical Record.**

- Diagnoses (admitting and subsequent).
- Temperature chart.
- Consultations.
- Medical notes.
- Medications.
- Laboratory test results.
- X-ray readings.
- Surgical and delivery records (anesthesia reports, operative procedures and findings).
- Nursing notes.
- One-page summaries (of entire hospital stay).
- Condition at discharge.
- Autopsy findings, if applicable.

Figure 3-1. The admissions record, the first part of the medical record, is compiled when the patient is admitted. The clinical record, the second part of the record, is a continuing history of patient treatment and physical history.

Continue with Exercises, Section I

EXERCISES, LESSON 3, SECTION I

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. According to the Joint Commission on Accreditation of Health organizations, the medical record serves as the basis for planning patient care and provides _____in evaluation and treatment.

   a. Continuity.
   b. Coordination.
   c. Accuracy.
   d. Acceptable standards.

2. The medical record provides documentary evidence throughout the course of a patient's medical evaluation and treatment, whether it be as an inpatient, an outpatient, during an emergency, or under a hospital-administered _____ program.

   a. Ambulatory.
   b. Home care.
   c. Critical care.
   d. Intensive care.

3. Medical records document _____between responsible practitioners and any other health care professionals contributing to the patient's care.

   a. Legal interests.
   b. Levels of responsibility.
   c. Antagonism.
   d. Communication.

4. Medical records can be used to protect the _____ of the patient, the responsible health care providers, and the hospital.

   a. Wishes.
   b. Morals.
   c. Longevity.
   d. Legal rights.

5. As long as the patient's identity is protected, medical records may be a useful source of _____for continuing education and research.

   a. Data.
   b. Evidence.
   c. Documentation.
   d. Criteria.

6. Because of the importance of the medical records as a record of patient care, a documentation of treatment, a legal record, and a basis for insurance reimbursement, it is critical that health care providers maintain records that are:

   a. Handwritten.
   b. Accurate and up-to-date.
   c. Biased in the patient's favor.
   d. Computerized.
   e. Immunization registers.

7. The medical record consists of the admissions record and the:

   a. Final record.
   b. Departmental record.
   c. Clinical record.
   d. Pathology record.

8. Which of the following is **NOT** a part of the admissions record?

   a. The patient's name.
   b. The patient's age.
   c. The record of lawsuits against the hospital, if any.
   d. Pertinent patient history.
   e. Reason for admission.

9. Which of the following is **NOT** a part of the clinical record?

   a. History of treatment.
   b. Physical history.
   c. Nature of complaint on admission.
   d. Admitting diagnosis.
   e. Immunization registers.

10. Which of the following is **NOT** a part of the clinical record?

    a. Subsequent diagnosis/diagnoses.
    b. Consultations.
    c. Medical notes.
    d. Dosimetry records.
    e. Medications.

11. Which of the following is **NOT** a part of the clinical record?

    a. Lab test reports.
    b. Paramedical documents.
    c. X-ray readings.
    d. Surgical or delivery records.
    e. Nurses' notes.

12. Which of the following is **NOT** a part of the clinical record?

    a. Insurance claims forms.
    b. Summaries.
    c. Condition of patient at discharge.
    d. Autopsy findings, if any.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3, SECTION I

1. a (para 3-2a)
2. b (para 3-2b)
3. d (para 3-2c)
4. d (para 3-2d)
5. a (para 3-2e)
6. b (para 3-3)
7. c (paras 3-4a & b)
8. c (para 3-4a)
9. e (para 3-4b)
10. d (para 3-4b)
11. b (para 3-4b)
12. a (para 3-4b)

Continue with Section II

Section II: PRIVACY AND CONFIDENTIALITY

3-5. THE PATIENT'S PRIVACY IN THE HOSPITAL

a. **Inevitable Intrusions on Privacy.** A hospital stay, by its very nature, entails constant and repeated intrusions on a patient's privacy. The patient will most likely be seen by the intern, the resident, the physician, the nurse, and other members of the health care team. All that is done for the patient and all reactions to treatment become a matter of record, open to those with a legitimate *need-to-know,* that is, those providing patient care.

b**. Protecting Personal Information.** The presence of the patient in the hospital may become a matter of public interest, when a prominent figure or a victim of an unusual occurrence, that is, a "Karen Ann Quinlan" or a "Nancy Cruzan" is concerned. The hospital authorities may then be flooded with inquiries about that patient's condition. The nurse, however, is under an obligation to maintain professional secrecy. The hospital should not release information of a personal nature to the press nor permit photographs without the written consent of both patient and attending physician. Both the codes of ethics for health care professionals and the Patient's Bill of Rights generally recognize the patient's right to privacy. (See A-1, principle 5, A-3, 14.)

c**. Limitations on Privacy for Public Figures and Noteworthy Events.** An individual may, by his or her own activities or by the force of circumstances, become a public personage and, thereby, lose a part of his or her right to privacy. Privacy is limited to the extent that the public has a legitimate interest in a public figure's affairs or character. The issuance of a marriage license or a birth may be a newsworthy event.

LIMITATIONS ON PRIVACY FOR PUBLIC FIGURES

In *Meetze vs Associated Press* (S.C., 1865), a man whose 12-year-old wife gave birth to a child filed suit against a newspaper for publicizing news of the birth. The court held that the birth of a child to one so young was, in fact, a matter of legitimate public interest, and the case was dismissed.

3-6. THE RIGHT OF PRIVACY

A hospital stay, by its very nature, involves inevitable infringements on privacy. But, the patient's right to privacy should still be respected to the greatest extent possible. In states where the concept of privacy is recognized, a person has the right to live his or her life, if he or she so wills, without having pictures published, business enterprises discussed, successful experiments written up, or eccentricities commented upon for the benefit of others, in any form or medium of communication. Privacy is a right based on constitutional and state statutes.

privacy: the right "to be let alone," to be free form unwarranted publicity, to live without having one's name, picture, or private affairs made public or published against one's will.

3-7. DEATH ENDS THE RIGHT TO PRIVACY, BUT NOT CONFIDENTIALITY

a. **Privacy, a Personal Right.** There is no right to privacy for a dead person. For example, the executor of an estate contracted with a film studio to make a film based on the life of the deceased. When the deceased man's brother objected, the court held that death had ended the individual's right to privacy. Privacy is essentially a personal right that does not endure after death, unless there is a contract. When the secretive Greta Garbo, a famous film star of the 1930's, died in 1990, the cause of death was not released by the press. The actress had stipulated, in writing, prior to death, that this information not be released.

b. **Provider's Duty to Protect Confidential Communications.** The right to privacy, however, should not be confused with the duty of the health care provider to withhold confidential information obtained in the course of treatment. Death does not terminate the privileged status of confidential communications (para 3-8).

3-8. CONFIDENTIALITY

a. **Protects Information Obtained in the Course of Treatment.** The confidentiality of patient information is intended to encourage openness on the part of the patient and his or her loved ones so that the best diagnosis and treatment can be provided. Even though some control is necessarily lost when access is given to one's personal history and physical person, generally some say over information generated about oneself is retained, at least in diagnostic and therapeutic contexts. For example, a physician may not grant an insurance company or a prospective employer access to medical information without the patient's authorization. Confidentiality also respects the patient's privacy; individuals should not have to reveal the details of their bodily condition to obtain medical care.

confidentiality: the ethical responsibility of health care providers to maintain the secrets of their patients, communicated to them or learned from observation, examination, or conversation, and not to communicate same except to those with an official need to know.

b. **Confidentiality vs Privacy.** The terms confidentiality and privacy both relate to the access others have to protected information. Confidentiality is based on the professional relationship; privacy is a general right of all. Confidentiality involves the professional's discretion in not disclosing private information revealed within the context of the patient-health care provider relationship. Privacy is a personal right. The professional's respect for the confidentiality of the client upholds the individual's right of privacy. The distinction between an infringement of confidentiality and an infringement of privacy has to do with how that protected information was obtained.

(1) Infringement of confidentiality. An infringement of confidentiality occurs when information disclosed by the patient, in confidence, to the health care practitioner is purposely revealed or inadequately protected.

(2) Infringement of privacy. An infringement of privacy occurs, on the other hand, if an unauthorized person gains access to information through means other than the direct and privileged confidence of the provider- patient relationship.

A BREACH OF CONFIDENTIALITY

A 19-year old woman comes to the x-ray clinic for x-rays. When asked if she is pregnant, she replies in the affirmative. She tells the radiographer that she does not want her husband to know about the pregnancy.

If, for some reason, the radiographer disclosed this privileged information to the woman's spouse, it would constitute a breach of confidentiality. It would only be appropriate to disclose information such as this to individuals with a legitimate need-to-know, such as the radiologist.

A BREACH OF PRIVACY

If an individual sneaks into a hospital record room, breaks into a hospital computer bank, or overhears information in a hospital corridor, a breach of privacy has occurred. The information was not obtained through the privileged physician-patient relationship, but through unethical means and without a legitimate need-to-know.

c. **Access vs Secrecy.** A contradiction between access and secrecy has existed since the beginning of medicine. Most health profession ethics standards recognize this contradiction. The Hippocratic Oath of Physicians states the following:

> "Whatsoever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."

This ideal of the privileged nature of disclosures within the physician-patient relationship soon came into conflict with laws requiring disclosure. The legal obligations of health care providers place external limits on confidentiality. The patient's confidentiality is, of necessity, less strictly observed within the health care community, as providers have a legitimate right to access. Confidentiality is more strictly observed when dealing with parties outside the health care community, individuals not having a legitimate need-to-know. There are recognized exceptions to the kind of information that can be considered confidential. For example, information on births and deaths must, by law, be routinely reported to health care agencies. Gunshot wounds and sexually transmitted diseases usually have to be reported to the public health department. The American Medical Association has revised its code to

reflect the legal requirements for disclosure: "A physician...shall safeguard patient confidences within the constraints of the law."[1] As stated earlier, the professional's respect for client confidentiality upholds the individual's right to privacy.

d. **Private Information Belonging Only to the Patient.** Confidentiality protects private information that belongs only to the patient. Such information should not be open to public scrutiny as it might cause embarrassment or harm, if divulged.

DALLAS SEXUALLY TRANSMITTED DISEASE (STD) REPORTING AFFECTS PRIVACY RUT NOT CONFIDENTIALITY OF PHYSICIAN-PATIENT DISCLOSURES

In Dallas, Texas, cases of sexually transmitted diseases must be reported to the city. In addition, the affected individual must be interviewed to determine the identity of sexual partners who might also be affected. The affected party must be escorted to the treatment center, if he or she refuses to accept treatment voluntarily, thus, to some extent; the individual's right to privacy is abrogated.

Disclosure of privileged information, on the other hand, is limited to legitimate needs of access within the medical community. (Those who have to know to provide treatment.) Information on treatment is not divulged outside the medical community. And so, confidentiality, the privileged nature of the physician-patient communication, is upheld.

e. **Confidentiality and Privacy in the Military.** In a military setting, the welfare of all soldiers is of concern in as much as the soldier's health affects military readiness to perform assigned duties. In those circumstances in which information is needed about the health of a soldier or when a medical procedure is necessary to restore the soldier to a duty status, the soldier's autonomy (determination), privacy, and confidentiality may be infringed upon, to some extent. Military medicine, however, follows the privacy/confidentiality standards set forth by the American Medical Association, except where obliged to do otherwise because of the mission. These exceptions are determined on a case-by-case basis.

3-9. CONFIDENTIALITY VS INTRAHOSPITAL ACCESS TO INFORMATION

a**. Accessibility of Medical Information to Hospital Staff.** As stated above, information gained though the examination or treatment of a patient is private (personal) and confidential (protected). Yet, there are legitimate needs of access to medical information. Medical information includes information pertaining to patient evaluations, findings, diagnosis, and treatment. It also includes information given to health care personnel in the course of treatment or evaluation. This medical information must be accessible to hospital personnel with a legitimate need-to-know who are involved in direct patient care, administration, and research.

b. **Patient Care.** Records must be readily accessible to the health care providers who need them in order to ensure the best possible care for the patient. While accessibility may increase the risk of unauthorized access by others, this is a necessary and calculated risk. There are more malpractice suits for improper care than for unauthorized access. And, the requirement for prompt and correct care may, at times, override the need to protect confidentiality.

c. **Administrative Uses.** Medical records are business records that must be accessible to hospital staff members for billing, filing, auditing, responding to inquiries, and defending potential legal actions (litigation).

d. **Research.** It is quite common to use records for research without patient consent, as long as the records are for bona fide research. Research by non-staff members should be subject to a hospital review and approval process, and the identities of patients should be protected.

FORCED DONORS VS THE RIGHT TO PRIVACY

In 1988, Tomas Bosze's 12-year-old son, Jean-Pierre, was diagnosed with leukemia after an unsuccessful attempt to find a suitable donor for a bone-marrow transplant, Mr. Bosze approached Nancy Curran, a woman with whom he had an affair 4 years earlier. She had since given birth to twins, Jean-Pierre's half brother and half-sister, who would be more likely than anyone else to be compatible donors.

Bosze requested that Curran have the twins tested as possible donors. When she refused, Bosze went to court in an attempt to force Curran to have the twins' blood tested and, if there were a match, to let physicians "harvest their marrow."

The risk of complications from withdrawing marrow through a needle from the donor's hipbone is relatively small. But the mother said she did not want to take that risk or put her offspring through any undue pain. An Illinois judge denied Bosze's request, ruling that to force a donation would be a violation of the twins right to privacy.[2]

LEGITIMATE NEED FOR ACCESS TO CONFIDENTIAL INFORMATION WITHIN THE MEDICAL COMMUNITY FOR:

- Patient care.
- Administrative uses.
- Research.

Figure 3-2. Information gained through the physician-patient relationship is confidential. But, there are legitimate needs for access to such information within the medical community.

3-10. CONFIDENTIAL AND PRIVILEGED COMMUNICATION

a. **Protecting Information Divulged With the Physician-Patient Relationship.** Information transmitted by a patient to his or her physician in consultation or treatment is protected under confidentiality laws, as a privileged communication. (Information transmitted to a physician outside the context of the professional relationship, i.e., on the golf course prior to the existence of a physician-patient relationship would probably not be protected by the confidentiality laws.)

> **privileged (confidential) communication:** communication between parties in a confidential relationship (physician-patient, lawyer-client, clergyman-layman, husband-wife). The confidence is transmitted under circumstances implying it shall forever remain a secret.

b. **Legitimate Breaching of Confidence.** The recipient of such a confidence cannot disclose the information as a witness (thus, breaching the confidence) unless required to by law. A judge may rule that the information is not confidential or that there is an overriding state interest that supersedes the patient's right to confidentiality.

(1) Factors to consider. Situations in which a breach of confidentiality may be justified usually involve the prevention of harm to others. Several factors must be considered. Which risks to others (risk to life, physical health, property, or reputation), if any, outweigh the rule of confidentiality? How probable and serious is the risk of harm? If the probability of harm is high and the consequences serious, there may be justification for a breach of confidentiality.

(2) Example 1. Consider the case of a soldier who confides to a military chaplain his intention to kill a particular named individual. The chaplain learns that the soldier, in fact, has the means to carry out the act. If there is intent, a real risk to a particular named individual, and the means to carry out the act, a judge may rule that the information is not privileged and that it is needed to show premeditation. There are also legal and moral obligations to divulge confidential information when necessary to report certain contagious diseases, gunshot wounds, child abuse, etc. There may be a need to breach a confidence if the probability of harm to third parties is high and the consequences are serious. Generally, however, there is no reason to break a confidence when there is a morally and legally acceptable alternative to disclosure.

(3) Example 2. Also, consider the case of an airline pilot who informs his physician that his 50-year-old mother has Huntington's chorea. This means that the pilot has a 50 percent chance of becoming afflicted with this disease. If the pilot were to develop Huntington's chorea, his ability to fly safely would be seriously affected, with potentially catastrophic results for large numbers of people. The pilot, however, refuses to take the test for the genetic marker for Huntington's chorea (a test that is 95 percent accurate) and refuses to inform the airline of the possible risk. Since there is a real possibility of serious harm on a large scale, this might be a situation in which the physician would have to consider breaking the confidence to prevent serious harm of a large magnitude to others.[3]

IS A BREACH OF CONFIDENTIALITY JUSTIFIED TO PROTECT SEXUAL AND NEEDLE-SHARING PARTNERS OF HIV-POSITIVE PATIENTS?

Should the physician or other health care professional violate the confidence of a patient who has tested HIV-positive in order to warn a spouse and lover of the risk? This breach of confidence would be limited to the amount and kind of information necessary to protect sexual and needle-sharing partners from exposure. (This assumes that attempts to persuade the patient to disclose the information or grant permission for the disclosure have been unsuccessful.)

Limiting the breach of confidence to only those who need to know is crucial because of widespread discrimination against those with the HIV infection. Ethically, there is a strong argument for informing spouses, sexual and needle-sharing partners, based on beneficence. A basic question is which strategy would save the most lives: notifying spouses or lovers or guaranteeing strict confidentiality? Would those exposed to the AIDS virus but not yet exhibiting the symptoms be less likely to seek testing if confidentiality were not protected? Or would carefully limited breaches of confidentiality to sexual or needle-sharing partners not discourage people from seeking testing and medical attention?[4]

For example, a married bisexual male with night sweats and a persistent cough tests HIV-positive, but refuses to tell his wife about his condition. He insists on strict confidentiality even though his wife is at risk for exposure and the children could end up losing both parents. The physician reluctantly agrees. The patient finally discloses the true nature of his illness in the last weeks of his life, his wife tests positive. One year later, she begins to show symptoms and blames the physician for failing to fulfill his moral responsibility to her and the children.

Based on situations like the one above and others, ethicists Tom Beauchamp and James Childress argue that "...the rules of medical confidentiality are not, at present, well delineated and would profit from a thorough restructuring.

c. **Purpose of Privileged Communications.** In *Tarasoff vs Regents of the University of California*, discussed earlier (MD0066, lesson 1), the majority opinion held that the therapist has a duty to protect an intended victim from violence. But a minority opinion, underscored the importance of confidentiality to the therapy process and to society at large. Without it, dangerous people would not seek therapy at all, and those who did would be less open in the therapy process and, thus, less likely to be cured. As the dissenting opinion suggests, it is critical to protect privileged communications. Otherwise, people would not speak openly about their conditions, and correct treatment would be jeopardized. Confidentiality is of paramount importance in health care, perhaps secondary only to the main goal of the relationship, namely providing quality care for the patient. (It should also be noted that besides encouraging full and frank disclosures to the physician by the patient, confidentiality also protects the patient from possible public embarrassment.)

d. **The Triangle of Confidence.** Medical details and anything else, which the physician may discover about the patient in consultation or treatment, is strictly confidential. When a clinician refers a patient to the radiology department for a diagnostic examination, the radiologist must be admitted to the clinician's confidence. Therefore, the radiologist must be told facts about the patient relevant to his or her diagnosis and treatment which the clinician has discovered. In a reciprocal manner, the radiologist admits the clinician to his or her confidence, sharing opinions based on the results of the radiographs that have been taken.

Figure 3-3. The radiographer, as technical assistant to the radiologist, belongs to the extension of the triangle of confidence and may be privy to confidential information.

(1) The exchange of confidential information within the triangle formed by the clinician, the radiologist, and the patient is totally appropriate. X-ray technologists, as technical assistants to the radiologist, must also be admitted, by extension, into this area of confidence, in order to perform their duties.

(2) X-ray technologists should be aware, however, of the facts that through x-ray reports and case notes they have access to information about the patient, which must always be regarded as confidential. Technically speaking, free discussion of the patient's condition should be limited to the original triangle (primary physician, radiographer, and patient). However, there are legitimate extensions of the triangle, i.e., staff members with a legitimate need-to-know. Some discussion must necessarily take place between various other members of the hospital staff: between junior radiographers and their seniors, between radiographers and other nursing staff charged with the patient's care, between radiologist and x-ray technologist.

(3) The triangle of confidence together with its legitimate extensions stops there. No detail concerning a patient (medical or personal) should ever be discussed with another patient or discussed outside the hospital. There is a natural desire to discuss aspects of one's work, especially if one is truly committed. Care must be taken, however, not to mention names if discussing a patient's case with family members or others.

(4) It is tempting to appear knowledgeable about a well-known patient, e.g., a singer with a head injury, or a high-ranking official suffering from a nervous breakdown. But care must be taken not to say more than might already have been released to the press. With regard to the patient and the x-ray technologist, the triangle of confidence is not a two-way street. The privileged communication is entirely one-way in that the information is volunteered by the patient to the health care provider.

e. **Ethical Responsibility.** Every member of the health care team has an ethical responsibility to preserve the confidentiality of the patient's personal and medical information, and to keep such information from individuals outside the medical community within the constraints of the law.

3-11. CONFIDENTIALITY: FACTS AND FICTION

In the modern hospital with its large and diversified health care team, its bureaucracy, and third-party payers, a large number of people have legitimate needs and responsibilities to examine the patient's chart. Most patients would probably be surprised at the number of individuals legitimately privy to their medical affairs.[6] Although most codes of ethics for health care professionals recognize the right to confidentiality, the reality of confidentiality as applied in the modern hospital is quite different from the ideal of the sacred triangle model of confidence (with its legitimate extensions), outlined earlier. Patients recognize that physicians commonly discuss cases for second opinions and they expect physicians to discuss things in more open professional settings. However, they would be surprised at the extent to which cases are discussed in medical journals, and more casually at parties, or with spouses and friends.[7]

Continue with Exercises, Section II

EXERCISES, LESSON 3, SECTION II

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. All matters relating to treatment become a matter of record available to:

   a. Those with a legitimate need-to-know.
   b. Individuals having an interest in the patient's condition.
   c. The press.
   d. Inquiry from any source.

2. Privacy laws ensure that the hospital will not release information of a personal nature or allow photographs without the written consent of the:

   a. Health care team.
   b. Patient's family.
   c. Patient and attending physician.
   d. Hospital ethics committee.

3. The right of privacy is limited by the public's legitimate interest in noteworthy events, victims of unusual occurrences, and the activities or character of:

   a. Private citizens.
   b. Public figures.
   c. Foreigners.
   d. Hospitalized individuals.

4. Diagnostic and therapeutic information learned within the context of the health care provider-patient relationship is protected by the right of:

   a. Privacy.
   b. Confidentiality.
   c. Autonomy.
   d. Informed consent.

5. Although the military follows American Medical Association (AMA) standards of patient confidentiality and privacy, there may be instances in which the autonomy, privacy and confidentiality of a soldier is _____. This may occur when a medical procedure is required to restore a soldier to duty status or when information is needed to determine a soldier's military readiness.

   a. Infringed upon, to some extent.
   b. Nullified.
   c. Totally invalidated.
   d. Upheld.

6. Which of the following would constitute a breach of confidentiality?

   a. The attending physician discusses the patient's condition with the radiologist.
   b. The x-ray technologist tells the attending physician about the results of an x-ray.
   c. A civilian nurse complains to the head nurse about the uncooperative nature of a patient.
   d. A civilian radiographer discusses a patient's case, by name, with someone outside the hospital.

7. Marriages and divorces are routinely published in the newspapers despite the personal nature of these events. This is an example of legitimate public interest in a noteworthy event, overriding the right to:

   a. Freedom of information.
   b. Confidentiality.
   c. Privacy.
   d. Informed consent.

8. The pilot of a commercial jet informs his physician that his mother has Huntington's chorea. Thus, the pilot has a 50 percent chance of developing the disease himself, in which case his ability to fly could be seriously hampered and he could cause serious harm to large numbers of people. The pilot indicates that he does not intend to take the test for the genetic marker for Huntington's chorea or inform the airline. This is a case in which:

   a. Strict confidentiality should be maintained.
   b. There are legally and morally acceptable alternatives to committing a breach of confidence.
   c. The physician may have to violate the confidence if the pilot continues to refuse to inform the airline, because the potential risk of harm is of such a large magnitude.
   d. The physician should conduct a risk-benefit analysis.

9. A calculated risk is taken in making confidential information readily accessible to hospital personnel, because:

   a. Unauthorized access is not a concern of the hospital.
   b. Confidentiality and quality care are almost always mutually exclusive considerations.
   c. The need for prompt quality care may, in some situations, override the requirement to protect confidentiality.
   d. You can't have confidentiality without free access to information.

10. Which of the following would constitute a breach of patient confidentiality?

   a. A health provider involved in the care of an HIV-positive patient reveals the identity of the patient to a co-worker who is not involved in the patient's care.
   b. The primary physician discusses her patient's case with the radiologist, who, in turn, discusses the patient with the x-ray technologist who will be taking the x-rays.
   c. A hospital researcher who has received proper authorization for his research project uses data from patient records while protecting the patient's identity.
   d. The hospital accountant reviews medical records that are required in preparation for an audit.

11. A breach of confidence made to protect third parties is most clearly justified when:

   a. The probability of harm is high and the consequences are serious.
   b. The probability of harm is low and the consequences are slight.
   c. There is the slightest potential for possible harm to others.

12. What type of information is considered privileged or protected under confidentiality laws?

   a. Conditions that are easily apparent, such as sunburn.
   b. General information.
   c. Information learned by the physician in consultation or treatment.
   d. Information revealed to a physician outside the context of the professional relationship, that is, on a golf course.

13. The triangle of confidence and its extensions cover privileged information shared during consultation and treatment by the patient, physician, radiographer, and:

a. Other members of the hospital staff with a legitimate need-to-know.
b. Any member of the hospital staff.
c. Government agencies.
d. The legal community.

14. The x-ray technologist must regard information about the patient, such as x-ray reports and case notes, as:

a. Suspect.
b. Part of the public domain.
c. Releasable.
d. Confidential.

15. Every member of the health care team has a (an) _____responsibility to protect patient information from release to individuals outside the medical community.

a. Legal.
b. Ethical.
c. Medical.
d. Military.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3, SECTION II

1. a (para 3-5a)
2. c (para 3-5b)
3. b (para 3-5c)
4. b (paras 3-8a & b)
5. a (para 3-8e)
6. d (para 3-10d)
7. c (para 3-5c)
8. c (para 3-10b (3))
9. c (para 3-9b)
10. a (paras 3-10a - d)
11. a (para 3-10b(2) & (3))
12. c (para 3-10a)
13. a (para 3-10d)
14. d (para 3-10d)
15. b (para 3-8a, definition)

Continue with Section III

Section III: CONFIDENTIALITY AND THE LAW

3-12. LEGAL RECOGNITION OF CONFIDENTIALITY

a. **Which Health Care Provider Relationships Are Protected?** Some states have enacted statutes to protect the patient and bar some overriding state interest. The physician protects the patient from disclosure of confidential communications, except upon consent of the patient. The law and the ethical codes differ on the issue of the confidentiality of the privileged communication. While medical codes of ethics for health care professionals recognize confidentiality as an ethical responsibility for all health care providers, the statutes exempting health care professionals from having to testify about confidential disclosures vary from state to state. Different health care providers are covered depending on the state. Some courts include one or more health care providers, such as x-ray technologists, by implication, on the theory that they act as agents of the physician. (The radiographer should be vigilant about protecting information gained through x-ray reports and case notes.) Other states include nurses, but not dentists. Still others, limit protection from the obligation to disclose to physicians and surgeons.

ESSENTIAL ELEMENTS OF CONFIDENTIALITY

- A physician-patient relationship exists.*
- The information was gained within the privileged relationship.
- The information was necessary and relevant to the professional treatment of the patient.

*States vary as to which health care provider-patient relationships are protected under the privileged communication statute.

Figure 3-4. Conditions required for a disclosure to qualify as a privileged (protected) communication.

b. **Other Medical Personnel.** There are no legal decisions as to the application of the doctrine of confidential communications to medical students, attendants, technicians, and nonmedical employees of the hospital. But, as stated earlier, all employees of the medical community have a moral (ethical) obligation to maintain secrecy.

3-13. ESSENTIAL ELEMENTS OF CONFIDENTIALITY

a. **The Existence of Privileged Relationship**. In order for a disclosure to qualify as a privileged communication, certain conditions have to be met. First, there has to exist a professional (physician-patient) relationship between the two parties involved.

b. **Information Gained Within Privileged Relationship.** The information has to have been gained in the context of a privileged relationship (physician-patient, lawyer-client, clergyman-layman, husband-wife). As stated earlier, states vary as to which health care-patient relationships are, in fact, privileged in the eyes of the law. Physicians, in any case, are protected under the privileged communication statute. However, only information learned within the context of the professional relationship is protected. For example, something the physician might have learned in a social situation would not be protected.

c. **Need and Propriety of Information.** The nature of the information must be such that it was necessary and relevant to the professional treatment of the patient.

3-14. LIMITATIONS ON CONFIDENTIALITY

a. **Information not required to Act as Physician or Surgeon**. Certain types of information are not protected under the confidentiality laws. Information not needed to act in the capacity of physician or surgeon is not privileged. If, during the course of treatment, a patient discloses his or her intention to rob a bank, that disclosure is not protected. And, the physician is obliged to report the patient's intent to commit the crime.

b. **Information that Is Plainly Observable to the Layman.** If a patient goes to a dermatologist to have severe sunburn treated, this condition would not be protected, as it is clearly *observable to* anyone. The same would apply for someone wearing a cast.

c. **Facts Acquired Before or After the Privileged Relationship.** If the information is learned *before or after* the physician-patient relationship was established, the information is not protected from disclosure.

LIMITATIONS ON CONFIDENTIALITY

- Information not required to act as physician or surgeon.
- Information plainly observable to the layman.
- Facts acquired before or after the privileged relationship.

Figure 3-5. Certain categories of information are not protected under the confidentiality laws.

Continue with Exercises, Section III

EXERCISES, LESSON 3, SECTION III

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. Barring any overriding state interest, _____is/are protected, in some states, so that the physician cannot disclose this information except upon the consent of the patient.

   a. Confidential communications made by the patient to the physician.
   b. Information learned outside the context of the physician-patient relationship.
   c. Facts that are generally known.

2. In some states, _____ may also be exempt from testifying about confidential disclosures, by implication, as an agent of the physician.

   a. The surgeon.
   b. The x-ray technologist.
   c. The radiologist.
   d. All hospital personnel.

3. While all medical personnel have a moral obligation to respect the confidentiality of their patients, there are no legal decisions regarding the exemption of _____ from testifying in court about a patient's personal or medical information.

   a. Radiographers.
   b. Surgeons.
   c. Nurses and dentists.
   d. Medical students, attendants, technicians, and nonmedical employees of the hospital.

4. Which of the following is **NOT** a characteristic of a privileged communication?

   a. A privileged relationship, that is, physician-patient, has to exist between the two parties.
   b. The information in question has been gained within the content of the privileged relationship
   c. The privileged information is revealed in a social setting.
   d. The information was necessary and relevant to the professional treatment of the patient.

5. Which of the following information would be protected under the confidentiality laws?

   a. Information not required to act as physician. (A cancer patient discloses his intent to access a computer data bank without authorization.)
   b. Information clearly observable to a layman. (A patient seeks treatment for severe sunburn.)
   c. Facts acquired before or after the privileged relationship. (A physician learns about a future clients sadomasochistic tendencies on the tennis court.)
   d. Medically relevant information learned during the medical examination and/or treatment.

6. The x-ray technologist should be aware of his or her duty to protect information about the patient:

   a. That is nonsensitive.
   b. That is easily observable.
   c. Learned through hearsay.
   d. Gained through x-ray reports and case notes.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3, SECTION III

1. a (para 3-12a)
2. b (para 3-12a)
3. d (para 3-12b)
4. c (para 3-13b)
5. d (paras 3-14a, b, & c)
6. d (para 3-12a)

Continue with Section IV

Section IV: ACCESS TO MEDICAL RECORDS

3-15. OWNERSHIP OF MEDICAL RECORDS

a. **The Hospital as Owner of the Forms.** Medical records, the hospital's business records, are retained for the benefit of the professionals who work with the patient. The law recognizes medical records (the forms or documents) as the property of the hospital that maintains them. Thus, the hospital must exercise control over access by outsiders. Records are protected from public scrutiny by the general practice of nondisclosure.

b. **The Hospital as Custodian of the Information.** Medical records are a special type of property. While the hospital owns the forms or other medium (computer software) on which the information is recorded, it is merely the custodian or keeper of the *information* contained in the record. The patient has a right to the information contained in the records.

THE HOSPITAL OWNS THE PHYSICAL RECORDS BUT NOT THEIR CONTENTS

In Cannel vs Medical and Surgical Clinic (III., 1974), the court ruled that the patient and others had a right of access to the information, in many circumstances. The patient and others did not, however, have the right of possession of the original records.

THE PATIENT PAYS FOR INTERPRETATION, NOT FOR THE X-RAY NEGATIVES THEMSELVES

In *McGarry vs J.A. Mercier Co.* (Mich., 1935), a patient was sued by his physician for failing to make payment for professional services rendered. The patient maintained that since the physician had retained the patient's x-rays, he (the patient) should not have to pay for them. The court ruled that the patient did not have a right to the x-ray negatives themselves. The court went on to say that the patient does not pay for a picture per se, but rather the interpretation of the x-rays.

c. **Army Medical Records.** Medical records generated within the Army are the property of the US Government. As such, they are subject to the same legal controls as other government documents. A military medical record differs somewhat from a civilian medical record in that the former also serves as an administrative document that can affect the soldier within the larger scope of his or her military career, in general.

3-16. AVAILABILITY AND RELEASE OF MEDICAL RECORDS

a. **For the Diagnosis, Treatment, and Prevention of Medical Conditions.** Medical records are used in the diagnosis, treatment, and prevention of medical conditions. If a patient is scheduled for a contrast study or special procedure, the medical records will accompany the patient to the radiology department. The radiologist must have the medical record at his or her disposal so that the patient's history and condition can be reviewed, and relevant factors, such, as possible allergies, susceptibility to fainting, etc., can be identified.

THE DUAL ROLE OF ARMY MEDICAL RECORDS MEANS WIDER ACCESS

A service member enrolled in the Army Substance Abuse Program (ASAP) is administratively attached to the program. This means that he or she cannot be reassigned for the duration of the program. Because of the dual (medical & administrative) role of Army medical records, personnel outside the medical community may have a legitimate need to access information in the records. For example, a commander who is planning future reassignments may wish to check on the length of the soldier's participation in an alcohol abuse program. A Company Commander with a soldier, who is chronically ill, may need to review an excerpt from the soldier's records relevant to his other area of concern. Generally in the civilian world, a boss would not have similar access to information contained in an employee's medical records.

b. **For Research**. Personnel involved in research have the right of access to a patient's medical records. They are, of course, bound by the same ethical requirement to protect the patient's identity (and privacy).

c. **For Legal Proceedings.** There may be occasions on which records are required for judicial proceedings. Hospital records may be admissible as evidence in a court of law, provided the records are duly authenticated and relevant to the issue on which the court is deliberating. State laws will vary on the issue of admissibility.

d. **For Hospital Accreditation.** When a hospital goes through the accreditation process, examiners review medical records to ascertain that they are kept in the prescribed manner; for example, that lab, x-ray, and other reports are filed, and that the outcome of scheduled exams is duly annotated. Accreditation is important for a military facility. The option to function as both a health care and a teaching facility, for example, is based on having exceeded accreditation requirements, and having the manpower and the caseload to warrant training.

e. **Third-Party Access Authorized By The Patient.** Patients may also authorize access to persons outside the medical community, e.g., insurance companies, lawyers, family members. All patient authorizations for release of medical information to a third party must be in writing. When medical information is officially required for uses other than patient care, only enough information to satisfy the request should be released.

f. **Patient Access.** Competent patients can generally authorize their own access to medical records concerning their care. Since records contain technical information, and many abbreviations and specialized terms, it is better for the patient to review the record with someone who can provide clarification, as required. The American Hospital Association also recommends that the attending physician be notified before the records are released, and many hospitals follow this practice. It is preferable, if the patient is willing, to have him or her accept information from the physician, rather than having the patient read the medical record. But, if the patient should wish to see the record, prompt and courteous access should be provided.

(1) The patient's motivations. If the patient feels a need to review his or her own record, the staff should cooperate. A review of the record can provide needed reassurance for a patient. It can satisfy curiosity and allay misgivings that there might be a cover-up or that information is being withheld. It can defuse a hostile provider-patient relationship and avert a decision on the part of the patient to hire an attorney or file suit to obtain the records.

(2) Patient reactions. The patient may have negative reactions to the contents of his or her records. He or she may become angered at seeing self-induced or fictitious illnesses identified as such or suspicions of a physician's lack of sympathy confirmed. Many patients are worried about their prognosis, fearing that the physician may not be telling them the true severity of their illness. In the latter instance, seeing the record provides the reassurance that they have been told all there is to know.

3-17. MEDICAL RECORDS IN THE RADIOLOGY DEPARTMENT

a. **The Importance of Consulting the Medical Record.** It is critical that the radiographer review the patient’s history before commencing any examination. The records should be checked before beginning any contrast or special study. The nurse should have completed an x-ray requisition, to include the patient's medical history so that the radiology department can proceed based upon a full knowledge of the patient's medical history. When this information is unavailable or disregarded the results can be disastrous.

b. **If the Records Are Unavailable.** Theoretically, patients who come for a contrast study will have their record with them. But, in fact, there are many times when the patient will appear empty-handed. This is why it is essential for the radiographer to ask the patient certain questions about his or her medical history before proceeding.

FAILURE TO CONSULT THE RECORDS OR QUESTION THE PATIENT ABOUT HIS OR HER MEDICAL HISTORY

A radiologist, assisted by an x-ray technologist, instructed a patient to step up onto the footboard of an x-ray table, which was in the vertical position. After the lights ware turned down and the fluoroscopic exam was begun the patient fainted and fell to the floor. The fall resulted in a fractured hip. This injury resulted in the need for an open reduction, which, in turn, aggravated a preexisting vascular disorder. The vascular disorder caused a pulmonary embolism, which necessitated additional surgery triggering a kidney Infection.

The court held that the radiologist had not acted reasonably by failing to acquaint himself with the patient's history before beginning the examination. He was, therefore, found negligent by failing to anticipate the possibility of the patient's fainting. The radiologist's failure to secure a history was held to be the proximate cause of the patients fall. Had a history been secured, it would have revealed a prior fainting episode and would have prompted increased alertness on the part of the radiologist and radiographer.

In addition to finding the radiologist negligent, the court also imposed liability upon the hospital. The hospital was held liable for the errors committed by the attending nurse and the x-ray technologist. The nurse failed to complete the may requisition or to include the patient's medical history. The x-ray technologist failed to anticipate the possibility of a fainting spell during the course of the examination. The court pointed out that x-ray technologists are trained to anticipate reactions such as fainting, and this knowledge imposed a duty to guard against this eventuality.

3-18. DOCUMENTATION

a. **The X-Ray Requisition Form (SF 519-A or-B).** The radiology department should enter an accurate and complete recording of the patient's exam on the x-ray requisition form (SF 579-A or-B). The x-ray technologist will need to review the clinical history, the history of treatment, and any allergic conditions before proceeding. If there is a request for a neck exam, the requisition form should specify which kind, soft tissue neck or cervical spine neck. By indicating what is wrong with the patient in the patient's history, e.g., penny lodged in the throat, the radiographer then knows that a soft tissue neck exam, and not a cervical spine exam, is required.

b. **Exposure Factors.** Correct factors should be used, following the guidelines set in the technical charts. Any deviations from the standard settings should be noted to assist in determining the appropriate radiation dose. Some activities do not require exposures to be written. Others require exposures only for fluoroscopy, while still others require exposures for all procedures. If the record indicates that the patient is pregnant, you should ask the patient if she is, in fact, pregnant. If she says "no" you should have her sign a statement indicating that she is not pregnant. If the patient later finds out that she was pregnant at the time of radiation, you will have the exposure

factors available to calculate the number of Rads to which she was exposed. Fluoroscopic time, generally 3 1/2 minutes, should be noted. Fluoroscopic units have timers that only go up to 5 minutes. But, you can reset the time if the procedure takes longer than 5 minutes.

c. **Contrast Media.** Contrast media should be documented, especially if anything goes wrong, such as a reaction to the contrast media. The type of media (barium, iodine solution, etc.), the amount (as exactly as possible), and the means of administration (oral, IV, tablets, injected in the muscle, etc.) should be indicated. Any unusual occurrences, such as a reaction to the contrast media, falling off the table, fainting upon standing, should also be noted.

d. **Information Provided to the Patient.** You will need to explain a number of things to the patient regarding the procedure and protective measures. However, diagnosis and prognosis are not your responsibilities.

(1) Procedures. You will need to explain all procedures to the patient, beforehand. "I'm going to inject a needle under the knee cap and inject some dye." You need to tell the patient only as much as he or she absolutely needs to know. Telling more than is necessary may only stress, confuse, and or frighten the patient.

(2) Protection. You will also need to explain about radiation protection. You might say something like: "You need to wear a lead apron so that we can protect your body from radiation." You should answer all questions that the patient might have, to the best of your ability but always limiting yourself to your area of responsibility, Questions regarding procedure and radiation protection are, however, within your area of expertise.

(3) Diagnosis and Prognosis. As stated, you should not discuss any aspects of the patient's diagnosis and prognosis. You should, instead, refer the patient to the attending physician for such questions. It is totally inappropriate to say, for example, "Gee, Mrs. Jones, it looks like you have an ulcer." If the patient asks, "Did I break my leg?" Your response should be, "I'm sorry, Mr. Smith, but Dr. Green will be in to answer your questions, in just a few minutes." If the patient asks, "How long do you think it'll take to heal?" You should reply that you are not in a position to respond. If the patient insists on a response, refer them to whoever is treating them. Some radiologists will not discuss anything with a patient, preferring to leave all matter for discussions to the attending physician.

e. **The Radiographic Report.** The radiographic report, signed by the radiologist, becomes an integral part of the patient's medical record. Three copies of the report are made: one for the physician, another for the medical records department, and another, for the x-ray clinic.

Continue with Exercises, Section IV

EXERCISES, LESSON 3, SECTION IV

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. The medical record itself, the form or other medium on which the data is stored, belongs to the:

   a. Attending physician.
   b. Hospital.
   c. Medical community.
   d. Patient.

2. As far as the medical record is concerned, the patient has a right to:

   a. The information contained in the records.
   b. The original copy of the medical record.
   c. Destroy all copies of the record.
   d. Limit the health care providers access to his or her records.

3 Information contained in the patient's medical records is **NOT** generally released:

   a. For diagnosis, treatment and prevention.
   b. For medical research.
   c. As admissible evidence in court proceedings.
   d. To hospital accreditation examiners.
   e. To third parties authorized by the patient.
   f. For use by the press.

4. Third-party access by lawyers, insurance companies, family members, etc. to information contained in a patient's medical records must be authorized by the _____in writing.

   a. Hospital.
   b. Attending physician.
   c. Ethics committee.
   d. Patient.

5. If the patient is not willing to accept information from his or her physician and wishes to review the medical record him-or herself, the hospital should cooperate with the patient's request to avoid:

   a. The appearance of a cover-up, allays fears, and defuses a situation that could lead to legal action.
   b. Charges of negligence.
   c. Upsetting the patient family.
   d. Bad public relations.

6. If a patient wishes to see his or her medical records, the patient's _____ should be notified.

   a. Next of kin.
   b. Attending physician.
   c. Attorney.
   d. Radiologist.

7. Since medical records contain technical information, abbreviations and specialized terms, the record should be examined by the patient with the help of:

   a. An attorney.
   b. A representative of the hospital ethics committee.
   c. Someone who can explain it.
   d. A paramedic.

8. It is very important for the x-ray technologist to check the before proceeding with any contrast or special study.

   a. Medical records.
   b. X-ray requisition form.
   c. Exposure charts.
   d. Contrast media.

9. A radiologist, assisted by an x-ray technician, instructed a patient to step up onto the footboard of an x-ray table, which was in the vertical position. After the lights were turned down, and the fluoroscopic exam was begun, the patient fainted, fell and fractured his hip. The attending nurse did not send the medical records along to the x-ray department. Is anyone negligent?

   a. The patient.
   b. The hospital.
   c. The radiographer.
   d. The attending nurse.
   e. The hospital, the radiologist, the radiographer, and the attending nurse.

10. If the patient comes to the x-ray department without medical records, the x-ray technologist should _____ before undertaking any procedure.

   a. Conduct the study anyway.
   b. Check patient's vital signs.
   c. Put the patient at ease and then proceed.
   d. Ask questions about allergies, and other relevant aspects of the patient's history.

11. The radiology department should provide an accurate and complete recording of the patient's examination on a(n):

   a. DA Form 31.
   b. Memorandum for Record.
   c. Dosimetry record.
   d. X-ray requisition form (SF 519-A or-B).

12. Correct exposure factors should be used and _____ noted.

   a. Deviations from the standard settings.
   b. Type of fracture.
   c. The weight of the patient.
   d. The amount of fluids consumed prior to the examination.

13. The type of contrast media, the amount, the means of administration, and any _____ should be documented.

a. Temperature change.
b. Hypersensitivity to dairy products.
c. Constipation problems.
d. Unusual occurrences.

14. Which of the following is **NOT** within the area of responsibility of the x-ray technologist?

a. Explaining procedures.
b. Reassuring the patient.
c. Outlining radiation protection measures.
d. Diagnosis and prognosis.

15. The radiographic report, signed by the_____ becomes an integral part of the patient's medical record.

a. Attending physician.
b. Head nurse.
c. Radiologist.
d. Radiographer.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3, SECTION IV

Be sure to re-read and study the paragraph(s) pertaining to any exercises you might have answered incorrectly. The relevant paragraph(s) is (are) listed after each of the answers below.

1. b (para 3-15a)

2. a (para 3-15b & anecdote, "The Hospital Owns the Physical Records But Not Their Contents.")

3. f (paras 3-16a - e, para titles)

4. d (para 3-16e)

5. a (para 3-16f)

6. b (para 3-16f)

7. c (para 3-16f)

8 b (para 3-18a)

9. e (para 3-17, anecdote, "Failure to Consider the Records or Question the Patient About His or Her Medical History")

10. d (para 3-17b)

11. d (para 3-18a)

12. a (para 3-18b)

13. d (para 3-18c)

14. d (paras 3-18d(1), (2), & (3))

15. c (para 3-18e)

NOTES

1. Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, Oxford University Press, New York, 1989, p 336.

2. Nancy Gibbs, "The Gift of Life-Or Else," Time Magazine, p 70, September 10, 1990.

3. Beauchamp and Childress, p 338.

4. Ibid., pp 339-340.

5. Ibid., p 341.

6. Ibid., pp 330-331.

7. Ibid.

End of Lesson 3

LESSON ASSIGNMENT

LESSON 4	Scope of Practice for the Radiographer.
LESSON ASSIGNMENT	Paragraphs 4-1 through 4-22
LESSON OBJECTIVES	Upon completion of this lesson, you should be able to:

4-1. Identify basic subject areas for which a radiographer is responsible.

4-2. Identify the meaning of the term "practice."

4-3 Identify the skill levels at which various duties are normally performed.

4-4. Identify scope-of-practice situations in the radiology department that may give rise to actions for liability for negligence.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

Section I: TECHNICAL KNOWLEDGE REQUIRED

4-1. INTRODUCTION

a. In order to do the right thing from the moral, legal, and technical standpoint, you need to have a clear perception of the requirements and limitations of your job. You must know what your duties are and what authority has been delegated to you. In a previous lesson, the practice of medicine was described as the blending of technical expertise, caring, and ethical values. (See MD0066, Lesson 1.) A realistic understanding of the scope of practice will contribute to an increased effectiveness in blending these three elements.

b. In this lesson we will consider the technical knowledge required to become a radiographer or x-ray technologist, the practice or practical application of that knowledge to the clinical setting, the specific duties officially designated for each skill level, and scope-of-practice situations in the radiology department which may give rise to actions for liability for negligence.

4-2. REQUIRED KNOWLEDGE BASE

a. **Knowledge, the Foundation of Clinical Practice.** As an x-ray technologist, you must be able to conduct radiographic examinations that meet current acceptable medical standards. You must be able to provide quality radiographs that aid physicians in diagnosing a patient's condition. You also have to function with skill and confidence in clinical situations at fixed or field installations, demonstrating your knowledge of a number of technical subject areas that form the basis of radiography. As soon as you enter the clinical phase of your training (Phase II), you'll have to demonstrate a working knowledge of such subjects as medical terminology, x-ray equipment, examinations, and radiographic production. A well-prepared radiographer is one who has a solid foundation in all of these areas.

b. **Standardized Curriculum.** The basic curriculum is the one that has been adopted by the American College of Radiology (ACE), the American Medical Association (AMA), the American Society of Radiologic Technologists (ASRT) and the Joint Review Committee on Education in Radiologic Technology (JRCERT). The Army in compliance with the Consumer-Patient Radiation Safety Act of 1981 adopted this curriculum. Successful completion of the curriculum in the resident phase of your training at the Academy of Health Sciences (AHS), US Army, and the clinical training phase at various US Army Medical Facilities does not signal the end of training. In a constantly changing field, such as radiology (which, of necessity, impacts on radiography), it is imperative that you take responsibility for your own continuing education if you want to keep current in the field. In the past, promotions were based on seniority and the amount of responsibility an individual assumed. A senior radiographer responsible for supervising a particular area in the department of radiology

would be promoted to assistant chief radiographer and finally to chief technologist. With the significant changes that have occurred in radiology, the potential for upward mobility has increased. But, today, upward mobility is based primarily on formal education. Radiographers interested in career mobility must examine their career priorities, assess their individual capabilities, and then begin investigating opportunities. In addition to postgraduate education, there are continuing education programs offered by the American Society of Radiologic Technologists and by state and local societies throughout the country. Certificates awarded upon completion provide documentation for earned continuing education points.

RADIOGRAPHERS SUPPORT CONTINUING EDUCATION

Rick Canton, M.S., R.T. and radiography educator at Lima Technical College, Lima, Ohio wrote to FT Image magazine to express his approval of continuing education requirements: "the extremely heavy clinical and academic efforts [required] before a student can qualify for the ARRT examination [are]...far from beyond reasonable limits..." He adds: "a profession-wide commitment to strive toward excellence ...speaks well for...progress [toward attaining] professional respect" In another letter to the editor appearing in the same column, Linda Cox, B S., at, remarks that the efforts of radiographers "to expand their knowledge beyond that gained in a two year radiography program" and to pursue careers in more advanced imaging modalities have contributed greatly to the profession's growth. Cox goes on to make the point that diagnostic radiography will only attain the stature it deserves as a field, in its own right, and not merely a stepping-stone to more complex imaging modalities, when "it is recognized as a specialized field and technologists are financially compensated for choosing to stay In this area." She concludes that "documentation that the profession is seeking to improve as a whole" through continuing education is the key to this process.[2]

"There is no indication that medical malpractice litigation is on the decline. In fact, society seems more litigious than ever. As the diagnostic radiologists and other medical imagers are moving into view as indispensable members of the health care team, so too are their attendant legal responsibilities."[3] --Albert Bundy, KID, J.D.

4-3. BASIC CURRICULUM

a. **Introduction to Radiography.** This course provides an overview of radiography and its role in the health care delivery system. The emphasis is on an orientation to academic and administrative structure, key departments and personnel, and the role of the profession as a whole.

b. **Medical Ethics and Law.** Ethical and legal considerations that affect practice are covered.

c. **Medical Terminology.** This course deals with word origins, word-building systems, specific anatomic terminology, abbreviations, and symbols. Included are terms referring to diseases and abnormalities that will enable the x-ray technologist to communicate effectively in the performance of radiographic procedures.

MEDICAL TERMINOLOGY

Without knowledge of medical terminology, you wouldn't be able to understand a physician's order that says: "syncope." If you didn't know that syncope means fainting, you might end up x-raying the patient without restraints. And, if the patient were to fall and incur an injury, you could be liable.

PRIMARY PHYSICIANS WITH IMAGING EQUIPMENT ARE FOUR TIMES AS LIKELY TO ORDER DIAGNOSTIC IMAGING

The health insurance claims of over 400,000 employees and dependents of several large American corporations were analyzed for frequency of diagnostic imaging. The frequency of imaging and Imaging charges were compared for two groups of physicians: (1) primary physicians with their own diagnostic imaging equipment (self-referring physicians) and (2) primary physicians who referred patients to radiologists (radiologist-referring physicians). Four clinical presentations were selected for their variety and volume of associated imaging procedures: 1) acute upper respiratory symptoms (how many chest radiographs were performed?); 2) pregnancy (how many ultrasounds were performed?); 3) low back pain (how many radiographs of the lumbar spine were performed?); and 4) difficulty urinating in men (how many excretory urograms, cystograms, or ultrasounds were performed?). The study revealed that for the clinical presentations considered in this study, patients were four times as likely to have diagnostic imaging performed when the primary physician *had his* or *her* own imaging equipment in the office than when the primary physician referred the patient to a radiologist. It is impossible to say whether the more liberal or more conservative use of diagnostic imaging represents the more appropriate care. Anyone of several factors could account for the markedly heavier use of diagnostic imaging among self-referring primary physicians: financial incentives; convenience of in-house equipment, or a tendency for physicians who favor imaging to acquire their own equipment The study findings conclude (hat "the differences between the self-referring and radiologist-referring physicians in the use of Imaging are so large that some concern over the role of financial incentives must be invoked."[4] The report concludes that' the potential to self-refer must surely complicate physicians' decisions and perhaps jeopardizes their obligation to place their patients interests above their own."[5]

d. **Human Structure and Function.** Outlined in this course are the structure and functions of the human body, with emphasis on cells, tissues, bones, organs, systems and their interrelationships. Also discussed are particular radiographic applications.

e. **Principles of Radiographic Exposure.** Primary factors affecting the production of radiographic images and secondary factors affecting their quality are considered. Laboratory exercises are used to demonstrate the application of these factors and to validate theories and concepts presented in the classroom.

f. **Imaging Equipment.** This course presents an overview of the equipment routinely used to produce diagnostic images, with particular emphasis on frequently used imaging equipment, recording media, and associated imaging techniques.

g. **Radiographic Film Processing.** This course introduces the basic principles of radiographic film processing. Specific topics covered include: requirements for the processing area, types of film, film holders, intensifying screens, processing procedures, and artifacts.

h. **Radiographic Procedures.** Procedures for taking radiographs and special studies of the upper and lower extremities, trunk, skull, digestive and urinary systems are covered.

i. **Evaluation of Radiographs.** This course considers criteria for evaluating radiologic examination requests, film identification, and radiographic quality. It draws on the knowledge and skills gained from a number of other courses in this curriculum.

j. **Radiation Physics.** This is an introductory physics course that emphasizes fundamentals of x-ray generation, production, beam characteristics, and units of measurement.

k. **Principles of Radiation Protection.** The x-ray technologist's responsibilities in minimizing radiation exposure to the patient, other personnel, and the public at large are considered. It is designed to allay the fear that the word "radiation" arouses in both x-ray technologists and patients. Specific topics include the use of beam restrictive devices, patient shielding techniques, proper screen-film combinations, accurate assessment and implementation of appropriate exposure factors, maximum permissible doses, and regulatory limitations.

l. **Principles of Radiation Biology.** This course introduces principles of beam formation and radiation interaction, with specific emphasis on the effects of radiation on cells, factors affecting cell response, and acute and chronic effects of radiation.

m. **Radiographic Pathology**. In this course, the impact of disease and abnormalities on the performance of radiographic procedures is considered.

n. **Introduction to Quality Assurance**. Covered in this course are testing procedures for radiographic and processing systems designed to assure consistency of quality images. Also covered are darkroom chemistry and processing procedures, sensitometry characteristics, preventive maintenance, knowledge of equipment, and state and federal regulations governing the radiographic environment.

AS LOW AS REASONABLY ACHIEVABLE

"As Low As Reasonably Achievable" is the guiding principle for radiation professionals around the world. Many states are now requiring those facilities where radiation exposure exists to put ALARA programs in place. The principle "ALARA" Is directed not only at the x-ray technologist but at the patient as well. Radiographers worry about working in a risky business. According to Robert S. Wenstrup, PhD, at the Lahey Clinic Medical Center in Burlington, MA, x-ray technologists "have a 1-in-10, 000 chance of suffering serious effects from radiation exposure." To put that in perspective he adds, "you can stay at home and have a risk of 1-in-20, 000 of falling down the stairs."[6] Patients worry that the radiation they receive during diagnosis and treatment will produce unwanted biological effects later on. Radiographers must keep ALARA principles in mind at all times to protect themselves and their patients from radiation exposure. They must also be prepared to discuss these principles with the public and with Joint Commission on Accredhahon of Healthcare Organization visitors.

RADIATION BIOLOGY

Knowledge of what happens when radiation interacts with the human body will give you a greater sense of commitment to protecting yourself and others from the harmful effects of radiation. Proper application of radiation biology principles is critical for reducing possible genetic damage to future generations resulting from unnecessary radiation exposure. You are more likely to remember to wear your lead apron, for example, if you have a full understanding of the effects of scatter radiation. You are more likely to remember to take one step back during a fluoroscopy procedure if you are aware of the fact that increasing the distance will decrease exposure.

o. **Introduction to Computer Literacy.** This course provides an overview of basic concepts of computer literacy with some consideration of applications in the radiology department.

p. **Field Radiography.** In this course, field x-ray operations, the medical units, Deployable Medical Systems (DEPMEDS), are described. Also included are practical exercises in the assembly and disassembly of field x-ray and processing equipment and tentage.

q. **The Radiographic Procedures Laboratory Practicum.** This hands-on course provides an opportunity to practice and improve upon skills learned thus far. Initially, nonenergized x-ray units are used to simulate exams up to the point of exposure. The student progresses to the use of energized x-ray units, making exposures on radiographic phantoms.

QUALITY ASSURANCE

Quality assurance is essential to ensure that a high standard of quality patient care is delivered. It is critical that you prevent unnecessary radiographic exposures and unreasonable waiting periods for patients undergoing exams in the radiology department and assure that the technical aspects of all procedures are carried out correctly. Consumer advocate suits brought forth by Ralph Nader and his group, "Nader's Raiders," resulted in legislation designed to protect consumers from incompetent operators of radiographic equipment whose negligent inattention to quality assurance resulted in radiation overexposures. Then efforts resulted in the Radiation Safety Consumer Protection Act of 1987.

r. **Clinical Education.** This is an approximately 880-hour practical learning experience in a direct patient care setting. Cognitive knowledge and skills learned in the preceding didactic phase are applied, with the goal of achieving competency in prescribed clinical areas.

Continue with Exercises, Section I

EXERCISES, LESSON 4, SECTION I

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. To function within the prescribed medico-legal guidelines and the professional code of ethics, a radiographer needs to know and stay within the limits of his or her:

   a. Duties and delegated authority.
   b. Intuition.
   c. Personal interpretation of clinical practice.

2. A knowledge of the _____ will help you to achieve a better balance of technical expertise, caring, and ethical decision making.

   a. Required curriculum.
   b. Scope of practice.
   c. Medical terminology.
   d. Local policies.

3. Radiography is a technical field requiring abroad knowledge base in a number of:

   a. Categories.
   b. Disciplines.
   c. Military occupational specialties.
   d. Subject areas.

4. The _____ of radiography involves putting your knowledge to practical application in the work setting.

   a. Study.
   b. Basis.
   c. Practice.
   d. Survey.

5. In a _____ field, such as radiography, it is incumbent upon the radiographer to take the initiative in pursuing continuing education.

   a. Constantly changing.
   b. Static.
   c. Controversial.
   d. Recognized.

6. Which of the following is **NOT** a subject of study for radiographers?

   a. Human structure and function.
   b. Medical terminology.
   c. Radiographic pathology.
   d. Medical ethics and law.
   e. Radiology department management.

7. Which of the following is **NOT** a basic subject area that radiographers are required to study?

   a. Patient care.
   b. Positioning techniques.
   c. Radiographic equipment repair.
   d. Principles of radiographic exposure.
   e. Quality assurance.

8. Which of the following is **NOT** a basic subject area for radiographers?

   a. Radiation physics.
   b. Radiation protection.
   c. Radiation therapy.
   d. Radiation biology.
   e. Computer literacy.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 4, SECTION I

Be sure to re-read and study the paragraph(s) pertaining to any exercises you might have answered incorrectly. The relevant paragraphs) is (are) listed after each of the answers below.

1. a (para 4-1a)
2. b (para 4-1a)
3. d (para 4-2a)
4. c (para 4-1b)
5. a (para 4-2b)
6 e (para 4-3)
7. c (para 4-3)
8. c (para 4-3)

Continue with Section II

Section II: PUTTING YOUR KNOWLEDGE BASE INTO PRACTICE

4-4. THE PRACTICE: PRACTICAL APPLICATION

a. **A Multi-Faceted Practice.** The knowledge base gained in the didactic phase (Phase I) and clinical phase (Phase II) of your training is put into practice almost immediately upon reporting to your duty station as a staff radiographer. The practice of radiography, as a whole, encompasses a variety of activities, not all of which are necessarily called into play in anyone given assignment. In the course of your career, however, you will probably have occasion to perform all the elements of the practice.

b. **Performing Radiographic Examinations.** A radiographer is expected to be able to perform radiographic examinations of all parts of the body for use in diagnosing disease and injury. (See figure below.)

RADIOGRAPHIC EXAMINATIONS

- Skull and head work.
- Thoracic radiography.
- Extremity radiography.
- Spinal radiography.
- Abdominal radiography.
- Fluoroscopic examinations.
- Special procedures.
- Rapid film changes in arteriography.

Figure 4-1. A radiographer is expected to perform radiographic examinations of all parts of the body for use by the physician/ radiologist in diagnosing disease and injury.

c. **Providing Optimal Patient Care.** As a competent health care professional, it is expected that you will use established and accepted techniques and protect the patient from radiation and other hazards. An x-ray is like a prescription drug in terms of importance and gravity. Its use cannot be taken lightly. You would not, for example, take an x-ray of a friend's leg to satisfy a passing curiosity about whether or not a sprain suffered several years earlier had actually broken the bone.

d. **Supervising Other Practitioners.** In your initial assignments you will do all of the busy work. But responsibility for supervising others may come sooner than you might have anticipated. Therefore, it is to your advantage to become aware of the supervisory and administrative aspects/operations of an x-ray clinic as soon as possible.

RADIOGRAPHERS HAVE AN ETHICAL AND A LEGAL OBLIGATION TO QUESTION ORDERS TO PERFORM PROCEDURES OUTSIDE THE SCOPE OF PRACTICE

In an address to the annual meeting of the Tennessee Society of Radiologic Technologists (1991), Michael R. Bloyd, R.T., R.N. expressed his concern about x-ray technologists who "carry out procedures on a daily basis that are legally [and ethically] questionable."[7] Bloyd maintains that "technologists should question any order from a physician that they are skeptical about or that they don't understand."[8] Some x-ray technologists don't feel a personal sense of responsibility for their actions because they rationalize that it is the radiologist who is ultimately responsible for what goes on in the radiology department. But, in fact, every x-ray technologist must, to some extent, assume personal responsibility for his or her own actions. Starting your own IV, injecting narcotics such as Valium, or injecting contrast agents are actions outside the scope of practice. Performing these tasks means that the x-ray technologist is actually "practicing medicine or nursing and that is against the law,"[9] says Bloyd. (One of the first questions an x-ray technologist would be asked on the witness stand was whether or not he or she knew the drug's contraindications and associated allergic reactions.)

It is also expected that you will competently and empathetically respond to patient concerns. This means communicating effectively with the patient. (See other column.) The patient expects to be treated well. You are expected to know what to do if your patient faints or falls off the bed, or suddenly grows sullen or uncooperative. When the physician requests a radiographic examination, you must be able to interact effectively with the patient, creating a caring atmosphere and presenting a professional demeanor that conveys competence.

e. **Platform Instruction.** Although you have been trained as an x-ray technologist, you could ultimately train other soldiers. Active duty service members at Phase II training sites, for example, can expect to have instructional responsibilities. Depending upon where you are assigned, you may or may not receive some training for this new role. The Academy of Health Sciences at Fort Sam Houston, Texas offers a course for incoming instructors. But at other locations, it could well be that you are thrown into the classroom without formal training. Therefore, you should take advantage of continuing education opportunities whenever they present themselves. If you are called upon to provide on-the-job training, you should welcome the experience as an opportunity to develop or enhance your skills. You never know when you may need these additional skills.

f. **Evaluating the Practice and Recommending Improvements.** You will be called upon to evaluate any or all elements of the clinical practice in the course of your career.

A FAILURE TO COMMUNICATE EFFECTIVELY WITH THE PATIENT

Failing to communicate effectively with the patient is one of the worst errors that an x-ray technologist can make. This is especially true when positioning the patient. If, for example, you are preparing to palpate the patient's pelvis to find the crest of the iIlium, you must be sure to explain to the patient what you are going to do and why. You need to explain to the patient what kind of discomfort to expect, if any. Imagine that you have positioned the x-ray tube, put the film in, and aligned the tube to the film. Your next step may be to align the patient. If you fail to explain this step, it may come as a shock to the patient, almost an aggression, when you push in really hard on the patient's pelvis. The patient may feel stressed and quite possibly become uncooperative and even belligerent.

Just such an incident occurred in real life, with the result that the patient in question filed a complaint for assault and battery. The complaint led to an investigation that revealed no substance to the allegation. But, from then on, the radiographer was watched more closely by his supervisor. In this case, the radiographer, a man in his 50's, was about to perform a chest x-ray in accordance with deeply ingrained habits he had picked up in the course of a long career. It was his practice to place his hands directly below the chest on the lateral borders, at the level of the lower ribs. He did so because he felt that this was the best way to ensure that the patient was aligned properly at the level of the lower ribs (so that the costophrenic angles of the lungs would not be cut off on the x-ray). Most patients don't like to be handled in this manner unless the need for this manner of touching is explained beforehand.

Even though the radiographer's name was eventually cleared, the incident haunted him from then on. His failure to communicate with the patient and his "history" of incidents (one incident) caused the supervisor to be reluctant to give this radiographer work on obstetric ultrasonography. The supervisor was concerned about the risk of another possible incident with a female patient. Thus, the incident continued to haunt the radiographer. It also has had adverse consequences in terms of covering patient work load and overall morale and operation of the radiology department.

(1) Becoming alert to the big picture. Learn to become aware of the overall workings of the radiology department and the hospital, as a whole, early on in your career. Make a concerted effort to take note of potential problem areas and, if nothing more, consider what you would do to resolve them if you were called upon to do so.

(2) Proactivity pays off. Give thought to possible solutions before you are asked to provide them. Ask yourself, "Why is there a long wait in this room? Is it because all of the head and chest x-rays are going to one room?" Since chest x-rays represent the greatest number of patients, maybe they should be spread evenly over all the rooms, instead of bottlenecking them in a single room.

(3) Diplomacy goes a long way. When offering solutions, be careful not to tread on sensitive egos. Most physicians (most people, for that matter) do not respond favorably to a suggestion, no matter how valid, if it is delivered with an "I can do better than thou" attitude. Frame your ideas diplomatically, focusing on the problem, rather than any perceived culprits: "Dr. Jones, I've been thinking about the bottleneck in room 12. Maybe, we could eliminate it if we .... Do you think it might be worth a try, for a few days?"

4-5. SCOPE OF PRACTICE

In 1987, the American Registry of Radiologic Technologists revised its "ARRT Rules and Regulations" and "ARRT Examinee Handbook" to include a scope of practice statement. The statement indicates that the radiographer's scope of practice is limited to those duties performed under the direction of a duly qualified physician. It is expressly forbidden for an x-ray technologist to diagnose a patient's condition (either orally or in writing) or to work independently, in a private office or institutional department.

IT'S NEVER TOO SOON TO LEARN THE ADMINISTRATIVE AND SUPERVISORY ASPECTS OF YOUR JOB

Sergeant Petri, an instructor (E-5) of ultrasound techniques, works in an organization with an NCOIC (E-6) and two other soldiers (E-5) who outrank him. Assuming that he will not have to take on any supervisory responsibilities for some time, he blithely goes about his business, conducting classes, pulling call, and doing night duty, *without paying particular attention to the overall workings of the clinic.* Then, one day, the NCOIC slot becomes vacant. And, to SFC Petri's surprise and dismay, he is the one selected for the job (his colleagues having been passed over for various reasons.)

Sergeant Petri is, however, *woefully* unprepared for the supervisory and administrative responsibilities he will soon have fulfill. Administratively speaking, the only thing he has done is order a few supplies and keep track of his own stock levels. Because of his failure to take an interest in the big picture, he will have a lot of learning to don in a short time.

Since responsibility tends to come earlier than one might expect in the military, you would do well to become aware of the overall operation and the administrative and supervisory dimensions of the job at all junctures of your career. Your turn at higher responsibility might come sooner than you may expect.

SCOPE OF PRACTICE

Unless licensed as a physician, applicants for registration shall agree to perform the duties of a radiologic technologist only as directed by a duly qualified physician and under no circumstances to give out oral or written diagnoses or work independently, whether in a private office or an institutional department. 'Duly qualified physician' refers to physician who has demonstrated education and training in the use and effect of radiation."

American Registry of Radiologic Technologists (ARRT) Rules and Regulations, August 1987

ADMINISTRATIVE DUTIES TAKE SOLDIER BY SURPRISE

Depending upon your assignment, you could be given the additional duty of supply clerk or any other administrative function, early in your career. Consider the situation of a Specialist (SPC) or a Private First Class (PFC) assigned as a radiographer to a clinic in Germany. The clinic in question oversees 10 other clinics, each having a single radiographer. The newly assigned SPC or PFC is designated the role of supply clerk. As such, he or she ends up having total responsibility for ordering patient care supplies within the x-ray department for all 11 clinics—quite a challenge for a relatively inexperienced x-ray technologist. Unquestionably, it is never too soon to become aware of the administrative component of your job.

Continue with Exercises, Section II

EXERCISES, LESSON 4, SECTION II

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. When you apply your knowledge to the day-to-day work situation of the radiology department, you are _____radiography.

   a. Practicing.
   b. Promoting.
   c. Learning basics in.
   d. Conforming to ethical and legal guidelines of.

2. Which of the following is **NOT** an element of the practice of radiography for the x-ray technologist?

   a. Radiation exams.
   b. Patient care.
   c. Supervision.
   d. Diagnosis and independent work.
   e. Platform instruction.

3. You should treat the patient with respect and a professional attitude that suggest:

   a. Formality.
   b. Competence.
   c. Intimacy.
   d. Emotionalism.

4. Being aware of the overall workings of the radiology department, and identifying problems and possible solutions can help prepare you for:

   a. Supervisory and administrative responsibilities.
   b. A job outside of your military occupational specialty (MOS).
   c. A new assignment.
   d. Civilian life.
   e. All of the above.

5. If you come up with a solution to a problem that exists in the radiology department, such as queuing of patients, you should state your proposed solution:

   a. By taking full credit for the idea.
   b. By making sure to identity who might have been to blame for the problem.
   c. Without appearing to question the efficiency or intentions of other health care professionals.
   d. Assertively and even aggressively, if need be, to ensure that your idea is implemented.

6. An x-ray technologist is **NOT** expected to perform radiographic exams:

   a. Of the skull and head.
   b. Of the extremities, spine, and abdomen.
   c. Involving the use of fluoroscopic techniques.
   d. Requiring rapid film changes for arteriography, and other special procedures.
   e. Requiring the interpretation of films produced by the radiographer.

7. Which of the following is **NOT** a scope-of-practice limitation established by the ARRT for x-ray technologists?

   a. The x-ray technologist must perform his or her duties under the direction of duly qualified physician.
   b. The x-ray technologist will refrain from making oral or written diagnoses.
   c. The x-ray technologist will refrain from working independently in a private office or an institutional department.
   d. The x-ray technologist will conduct radiographic examinations only if a physician is present.

8. The designated duties established for each skill level are:

   a. Strictly adhered to as mandated by US Army regulations.
   b. General guidelines for the military radiographer.
   c. For student radiographers only.
   d. Not applicable to NCOs below E-7.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 4, SECTION II

1. a (paras 4-4a and 4-1b)

2. d (para 4-5)

3. b (para 4-4c)

4. e (para 4-4f and anecdotes: "It's Never Too Soon To Learn the Administrative and Supervisory Aspects of Your Job" and "Administrative Duties Take Soldier By Surprise")

5. c (para 4-4f(3))

6. e (para 4-4b)

7. d (para 4-5)

8. b (para 4-4, anecdote: “It's Never Too Soon to Learn ...”)

Continue with Section III

Section III: DUTIES BY SKILL LEVEL

4-6. SKILL LEVEL 1: 91P10 (E-1 THROUGH E-4)

a. **Introduction**. This somewhat dry section of the lesson covers duties by skill level as prescribed by the official guidelines of AR 611-201, Enlisted Career Management Fields and Military Occupational Specialties. As an entry-level radiographer, you will be required to do many things, but the following section describes the tasks that you will be expected to learn and for which you will be expected to demonstrate proficiency. This material is included because you need a clear sense of what is expected of you at each skill level in order to do what is right from the ethical and legal standpoint. That said, it must also be recognized that the formal guidelines are only that-guidelines. What you actually do on the job will depend on the unique requirements of your assignment, e.g., the patient load, the number of x-ray technologists assigned to your department, etc.

b. **Interpreting X-ray Requests and Physician's Orders**. As an entry-level radiographer, you will be expected to accurately read and interpret x-ray requisitions and even medical records, if necessary. You must be able to understand precisely what examination(s) and position(s) the physician expects you to perform. Included on most requisitions are patient histories and medical information that may be critical for you to interpret so as to avoid harming the patient and to perform your job successfully.

c. **Moving and Escorting Patients Within the X-Ray Area.** You will find that most patients requiring an imaging procedure, whether it is x-ray, ultrasonography, magnetic resonance imaging (MRI), or computed tomography (CT), will be able to walk and get from one place to another with little or no problem. There is, however, a small percentage that may have to be moved by wheel chair or stretcher or require your assistance to get them to the x-ray area. This may sound easy. But, in fact, there are many things to consider when moving or escorting a patient. Your patient may have a potentially fractured bone or a severe hemorrhage or laceration. Your patient may be an invalid or a newborn. Each of these situations requires expertise and know-how. Have you ever lifted a 350-pound person?

d. **Preparing, Assembling, and Adjusting Instruments, Materials, and Equipment.** A radiographer should be organized and prepared prior to performing any radiographic examination. For each patient on whom you perform an exam, you must prepare the room by ensuring that all x-ray equipment is set and that medical materials are at hand and in readiness. All positioning items to include proper cassette choice, immobilization devices, and film identification markers must be ready for use. In addition to preparing the equipment, you must also think about mentally preparing yourself and the patient for what is to come. Before each examination, you should think about how you would feel if you had to hold a position that might be uncomfortable or painful for an extended period.

e. **Performing Special Exams**

(1) Soft tissue radiography. These are required to image small differences in soft tissue. Examples of exams requiring this technique are mammograms to study the tissue within the breast, exams of the extremities to find foreign objects that may have entered the body through trauma or swallowing. An example of the latter would be a large splinter of wood.

(2) Bone surveys**.** Bone surveys are performed to evaluate the spread of cancerous tumors or arthritic changes in joints such as the hands, knees, ankles, feet, etc. Bone surveys are used to evaluate possible delayed or premature bone development in children and to assess suspected child abuse by taking selected radiographs of the extremities of the body. Typically, a 91P10 operates x-ray-producing equipment that may be permanently installed in a hospital radiology department and/or mobile equipment designed for bedside radiography. The 91P10 may also operate mobile x-ray equipment especially suited for deployment to the war theatre.

f. **Assisting with Body Section Radiography.** Radiography of a layer or section of the body is known by a number of names, e.g., tomography, stratigraphy, or laminography But, this procedure is most commonly referred to as tomography, The entry-level radiographer is required to assist the more senior radiographer, usually an NCO, in performing these exams. Tomography requires the movement of the x-ray tube and film in conjunction with each other. The radiographer sets a fulcrum point, which is the desired focal plane that the radiologist requests to be demonstrated. Another type of tomography that has rapidly spread throughout the medical field is Computerized Axial Tomography. This type of tomography requires the use of a computer to generate body sections and has, for the most part, replaced traditional tomography, except in those cases where high contrast in tissues is required.

g. **Assisting with Routine Fluoroscopy Procedures.** For lower gastrointestinal (GI) tract exams, you will perform a variety of tasks. You may have to prepare the patient for a barium enema, assist the radiologist in performing the fluoroscopic procedure, and/or perform follow-up films to assist the radiologist in his radiographic evaluation of the patient.

h. **Assisting with Foreign Body Localization**. As an entry-level radiographer, you would assist in this procedure if, for example, a hemostat had been left inside the patient during surgery or a child had swallowed a marble. In such cases, the physician would require two views of the foreign body to determine how far it lay in either direction to pinpoint its exact location.

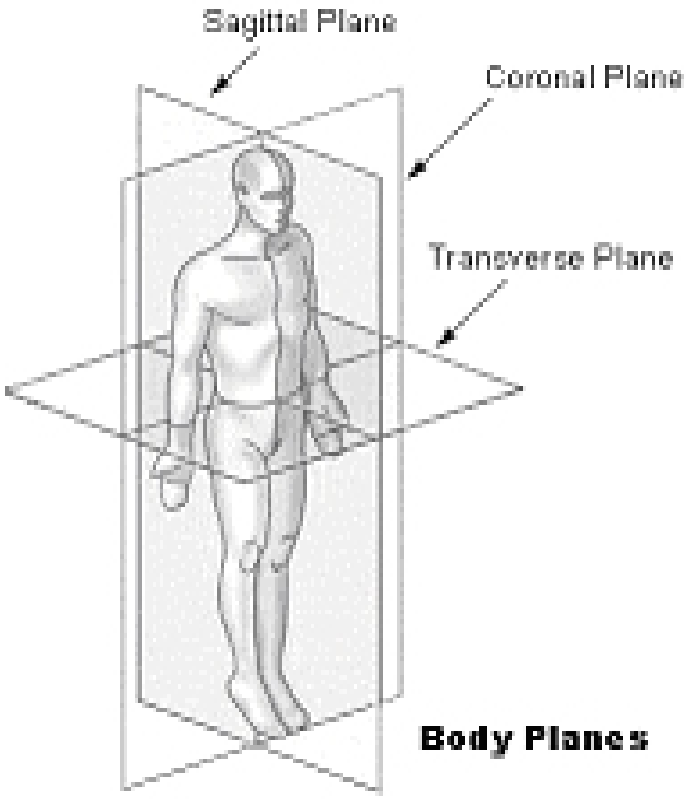


Figure 4-2. You will have to assist with such special procedures, as a body section radiography, which produces visual slices of the human body by means of computerized axial tomography.

i. **Assisting with Prenatal Procedures**. Whenever radiography is considered for use as part of prenatal care, the benefits of the exam must outweigh the inherent risks associated with exposure for the fetus. Although ultrasonography has replaced radiography, there may be occasions on which a prenatal radiograph or fetogram may be required. Prenatal radiographic procedures may be necessary if the mother has broken her back in a car wreck, or if something is suspected to be wrong with the fetus. A fetogram may be needed to determine if a mother's pelvis is wide enough to allow passage of an irregularly positioned infant, for example, a breach baby. However, prenatal radiography is not justified, for example, to determine if a baby's head is bigger than the vaginal opening. (Legal action is not likely to ensue just because the physician opts for a Caesarean section.)

j. **Assisting with Urogenital Procedures**. Included in this category are the intravenous pyelogram and the hysterosalpingogram (HSG). The IVP is used to check functioning ability. An HSG of the uterus and fallopian tubes may help to reveal why a woman is having difficulty getting pregnant.

k. **Assisting with Pediatric Radiography**. A child has just come from the lab kicking and screaming because he has been stuck with a needle. He wiggles so much during the x-ray that you have to take the same x-ray again. But, before you can do that, you have to calm down the child. You also have to deal tactfully but firmly with the fretful parents and possibly get them to leave the room. It takes all the competence, patience, and ingenuity you can muster to deal effectively with young patients and their parents.

l. **Assisting with Respiratory Procedures.** Respiratory procedures are not limited to the lungs. The bronchogram, an x-ray of the bronchial tubes, is one of several special respiratory procedures used to study the bronchial tree. However, this procedure is becoming less common as computerized axial tomography and magnetic resonance imaging technology begin to replace bronchograms. Computerized axial tomography is the preferred procedure because it is not invasive.

m. **Cleaning Intensifying Screens**. You may be cleaning intensifying screens as early as Phase II training, or as part of on-the-job training. Screens have to be cleaned to meet regulatory requirements. Though it may seem like a housekeeping chore, the proper care of the intensifying screen is of considerable importance in terms of protecting the patient from needless repeat radiographs. For, if the intensifying screen is dirty or scratched, the radiograph may have an artifact obscuring an important area of the anatomy. Consequently, failure to properly clean the screen may leave the x-ray technologist no other alternative but to retake the radiograph, thus exposing the patient to unnecessary additional radiation.

n. **Performing Manual and Automatic Processing Procedures**. This task involves taking film out of the cassette and putting it into the automatic processor through the feeding tray. Only capable radiographers can work in the darkroom because of the high potential for mishaps. The Army is negotiating to obtain automatic processing equipment for field use. Since some field units still use the manual procedure, you should be familiar with manual processing, so that you will be prepared, should you be assigned to a field unit that still uses these procedures.

o. **Applying Radiation and Electrical Protective Measures**. The voltages that are required for the production of ionizing radiation require high-tension transformers and other electrical components. If this equipment is not properly grounded and safety measures are not followed, potentially severe injury or death could occur. If proper radiation safety practices are not followed, excessive and unnecessary exposure to ionizing radiation could also occur. An awareness of these inherent dangers can provide the impetus for following the required protective measures more diligently.

p. **Performing Routine Patient Administration.** When you are assigned to the front desk, you will be charged with greeting patients, receiving and processing requisitions, and ensuring proper recording and entering of data.

q. **Maintaining X-ray Film Files.** When a patient has a medical visit, the physician will ask what is wrong, he or she will check for physical problems and make recommendations for treatment. All of this will be recorded in the patient's medical record. The same goes for x-rays. The films must be kept because they constitute a pictorial history of the patient's condition. Storing of radiographs requires accuracy and organized methods for proper care of this essential component of a medical record.

r. **Inspecting and Maintaining Equipment.** Inspection and maintenance are critical in a patient care situation that involves exposing the patient and possibly other personnel to ionizing radiation. You will be looking for such irregularities in the equipment as cracks in the lead aprons and potential electrical hazards, such as frayed cords and poor connections that could have serious adverse effects upon the patient and/or the radiographers.

s. **Packing, Unpacking, Loading and Unloading Equipment.** In the field, you will be called upon to assist in the setup and disassembly of an entire radiology department. This involves manual labor and knowledge of how a radiology department is organized, skills you will learn more fully when you are actually assigned to a field unit.

t. **Assisting with Setup of Equipment and Shelters.** You will have to assist in the setting up of such equipment as the temper tent and the iso-shelter.

4-7. SKILL LEVEL 2: 91P20 (E-5)

a. **Performing the Duties of the Previous Skill Level.** A 91P20 will perform all of the duties of the previous skill level, in addition to other skill level-unique functions. As you can well understand, the breakdown of duties by skill level serves only as a general guideline as to what you may be called on to do once on the job. In reality, there is a great deal of overlap, which means that you may be required to perform functions at a higher or lower skill level at any time, as the need arises.

b. **Providing Technical Guidance.** As a more experienced radiographer, you will have to provide guidance and informal on-the-job training to newer staff members. This experience will prove useful if you are ever assigned the job of platform instructor. Thus, providing technical guidance should not be viewed as an annoyance or as a task irrelevant to your primary mission. By assisting less-experienced staff members, you will be contributing to the efficiency of the radiology department as a whole. And, as stated earlier, keeping an eye on the big picture will stand you in good stead if and when you are asked to assume a leadership position.

c. **Disseminating Radiographic Reports.** You will have to provide x-ray findings in the form of reports. The radiologist's written report is not just one more form. These reports must be disseminated in a timely fashion for use in the patient's medical record to the attending physician and the appropriate clinic, hospital ward, or unit.

d. **Assembling Radiographs for Reading.** The noncommissioned officer (NCO) will evaluate film quality and ensure that all films assembled for any examination are properly filed and available for interpretation by the radiologist.

e. **Performing Special Exams**. At skill level 1, the x-ray technologist merely assists with the exams listed below. At skill level 2, you will be performing these duties independently. You might be the only one on duty in the middle of the night. Therefore, you must be able to perform the following exams:

(1) Body section radiography.

(2) Foreign body localizations.

(3) Prenatal X-ray exams.

(4) Pediatric X-ray exams.

f. **Performing Follow-up on Radiographic Exams**. Follow-up radiographic exams will occur mainly in the area of fluoroscopy. The radiologist will ask you to hand him or her the overheads for review. To do this efficiently, you must be able to communicate with your patient and radiologist, perform the follow-up films required, and assemble the films. In the case of a barium enema, the physician will perform the fluoroscopy and take spot films during the procedure. He or she will then depart, leaving you to convince the patient to retain the barium for the additional pictures. You may also have to provide follow-up radiographs in any of the areas listed below:

(1) Digestive system.

(2) Respiratory system.

(3) Vascular system.

(4) Nervous system.

g. **Taking Radiographs on Portable Equipment**. You will have to take x-rays of the extremities, trunk, and skull using portable equipment. This entails taking the machine to various locations, such as the operating room (OR), hospital wards, such as the intensive care unit and/or the emergency room. (Though, strictly speaking, this is a skill level 2 duty, but you may on occasion, have to perform this task as early as skill level 1 and even during on-the-job training.)

h. **Assisting with Special Radiographic and Fluoroscopic Procedures**. You, as an NCO, play an important part in assisting the radiologist in such exams as: angiography, venography, arthrography, etc.

"SUPERTECHS" STAY IN THE RADIOLOGY DEPARTMENT, WHERE THE BACKLOGS EXIST, WHILE FLEDGLING X-RAY TECHNOLOGISTS ARE SENT OUT TO DO THE PORTABLES

Since backlogs generally develop in the radiology ward, it is the newer, slower x-ray technologist who is more likely to be sent out of the department to do the portable exams. A recent graduate can take about one picture every 3 minutes. Thus, it will takes relatively Inexperienced X-ray technologist about 10 minutes to complete x-rays for a patient requiring three to four pictures. The highly skilled and experienced "supertech", on the other hand, can complete 10 patients In 15 minutes. That is because the seasoned radiographer doesn't have to slop to think of the correct procedure. This means that on a slow day, the experienced radiographer will have done four patients for every one patient an inexperienced x-ray technologist can do.

Thus, if the waiting room is filling up with patients and there is a need for portable exams in the OR, it is generally the newer x-ray technologist who will be sent out. The x-ray department workload supervisor cannot afford to sacrifice the "supertech" to the OR, because the biggest backlogs occur in the radiology department. (The biggest backlog occurs for patients requiring radiographic examinations.)

Consequently, it is the 91P10 who will be sent to the OR. A "supertech" will probably show you how to change into a gown, booties, and mask and will help you to setup. Then you'll wait in the lounge, eating doughnuts and reading magazines until someone yells, "x-ray!" You'll lump to your feet, take a few x-rays, and then go back to the lounge for another 40 minutes. According to the Army Testing Board, this is, strictly speaking, a lob for an E-5. In fact, you will be doing portable exams as early as your on-the-job training, for the reasons stated above.

4-8. SKILL LEVEL 3: 91P30(E-6)

a. **Performing Duties of the Preceding Skill Levels.** The extent to which you perform the duties of the preceding skill levels will depend, in large measure, upon the influx of patients at the clinic to which you are assigned. At a location such as Walter Reed Army Medical Center, which may have only 20 E-6's and a heavy flow of patients, E-6's are likely to be performing essentially the same patient care duties as junior personnel. It is at skill level 3, however, that you will start to assume significant responsibility for ensuring the safety of clinics, personnel management, and supervision, as outlined in paragraphs 4-8b. through 4-8h, below.

b**. Operating Audiovisual Equipment.** Some radiographic procedures require the use of audiovisual equipment, such as: videocassette recorders (VCRs) and cine projection systems. You will have to show slides or video recordings of radiographic examinations and provide in-service training on the use of the equipment.

c. **Testing and Calibration.** You will need to be able to test and check the calibration on your own x-ray equipment.

d. **Inspecting X-ray Clinics**. Although strictly speaking, a skill level 4 duty, you may actually be inspecting clinics at skill level 3. When you inspect an x-ray clinic, you will be looking for compliance with radiation safety procedures. You will also have to initiate corrective action, where appropriate. Seemingly obvious and important protective measures are sometimes overlooked. That is why inspection takes on great importance.

(1) Faulty equipment. The skill level 3 noncommissioned officer has the responsibility to ensure that he or she protects the patient from unnecessary radiation exposure, unclean/ unsanitary conditions, and electrical hazards. The NCO is also required to advise subordinates who are in error for one of the above conditions and outline the necessary corrective actions that must be taken. Those trying to get the job done sometimes neglect a simple task like turning off a machine that emits too much radiation and using another until it can be repaired.

CONVENIENCE VS SAFETY

When overwhelmed by the immediate and pressing demands of a heavy patient flow, one might be tempted, to some extent, to overlook safety in favor of convenience. In such circumstances, some radiographers allow the urgency of the moment to prevail over the ethical responsibility to limit the patient's radiation exposure to the lowest amount possible.

For example, an x-ray technologist is taking x-rays on a soldier using a defective collimator. The x-ray technologist is unable to collimate down to the appropriate size. Thus, radiation is projected well beyond the area marked by the beam of light. If the radiology department were shut down, however, the main department would have a much greater workload, with an increase of at least 50 to 60 more patients per day. In addition, the x-ray technologist would have to be sent out of his or her routine area.

Rather than shut down the department, the supervisor instructs the x-ray technologist to put a lead shield around the areas that don't need to be x-rayed to compensate for the faulty collimator that is not sizing down to the appropriate size. But, the x-ray technologist chooses not to use the lead shield, rationalizing that the patient won't really be exposed to that much more radiation, The patient is, in fact, exposed to unnecessary radiation not only in the targeted area (the chest, in this case) but from the top of the head to the feet.

(2) Protecting the patient. Many x-ray technologists fail to adequately protect the patient with lead shielding. For example, when taking an x-ray of the femur, a collimator is used to make the cone of light small enough so that it won't penetrate into the gonad area. You may think that the light won't scatter outward from the target zone. But, in fact, there is some scatter effect. Therefore, a piece of lead should be placed across the patient because the collimator eliminates almost all, but not all, radiation.

(3) Having third party hold the film with no lead shielding. A man accompanies his "drunken" friend into the emergency room. The man (helper) is asked to hold the film while his inebriated friend is x-rayed. But, the helper is not provided with a lead shield. If ever you should witness this kind of abuse, it is your duty to take immediate action to institute the required protective measure.

e. **Establishing Work Schedules.** Organizing the work schedule can be a very demanding task when you are in charge of an x-ray department, which is understaffed and over tasked, a somewhat common occurrence in an x-ray clinic. You may be assigned to manage a department that is open 24 hours a day with no one at the front desk and only seven x-ray technologists, who have to cover three x-ray rooms, an OR, and two other locations at which portable x-ray machines are needed. In the civilian world, mobile units are paid by the number of exposures taken. This provides a greater incentive for maximum efficiency than blanket payment by military rank does. (In the military, payment is more or less based on an hourly wage, although one is technically on duty 24 hours a day.)

f. **Assigns Duties.** The administrative task of assigning duties is more difficult than it might seem, because fragile egos are inevitably affected in the assignment of duties. Depending on the nature of the assignment, personnel may mistakenly assume that there is favoritism or persecution involved when, in fact, you are simply trying to get the job done and all the duties covered. It may seem to some employees that they are always being assigned to fluoroscopy. Or, after one too many instances of having to deal with the mess of a blown barium enema bag, the x-ray technologist might conclude that he or she is always getting the dirty jobs. Though the problem may simply be the x-ray technologist’s misperception of events, you still have to deal with not only a fair distribution of assignments, but also disgruntled personnel.

g. **Instructing Personnel.** By the time you attain the rank of E-6, you yourself may have become one of the "supertechs," described earlier. It will then be your turn to provide on-the-job training to less experienced x-ray technologists. By skill level 3 you may also be expected to conduct formal platform instruction. (Most E-6 x-ray technologist slots are at the Academy of Health Sciences, Fort Sam Houston, Texas, as platform instructors.) So, you may well end up on the platform by skill level 3. You may even be called upon to serve as a subject-matter expert, providing your expertise in the development of field manuals, training manuals, and various other training materials.

Subject-matter experts assist those who develop training materials by ensuring that the content is current, accurate, and consistent with Army medical doctrine. The correspondence course you are studying right now was developed with just such help from a 91P instructor assigned to the Academy of Health Sciences.

h. **Supervision.** Supervision covers a broad spectrum of duties.

(1) Preventive maintenance of equipment.

(2) Toxic environment procedures. X-ray technologists working under your supervision have a right to expect a safe working environment. This includes proper ventilation, enclosed areas, proper equipment for handling film chemistry and chemical treatment equipment for reacting immediately to on-the-job injuries or mishaps.

(3) Unit equipment and shelters. You will be responsible for supervising equipment and shelters and establishing procedures for unpacking, loading, unloading, setting up, and repacking them.

i. **Evaluating Personnel Performance.** Personnel evaluation is an area in which ethics and objective assessment, not personalities, should be the guiding principle. Admittedly, it is always difficult to pass judgment on colleagues, especially when ratings affect career progression. However, you must do what is right, and what is right is to objectively compare the job done to the job required, and rate accordingly. You should be aware that there is a natural tendency to rate people we like higher than others. You must consciously strive to put personal feelings, positive or negative, aside when wearing your evaluation hat. It is also unethical to look the other way when an employee is clearly not performing up to standard.

j. **Counseling Employees.** It is your responsibility, as supervisor, to counsel your employees. Be specific when describing a problem behavior, citing actual instances of the undesirable behavior, and outlining a course of corrective action to be accomplished within a specified time period. This is not an easy thing to do, since no one accepts criticism gracefully. In a training environment, the nature of the counseling required will be different than that provided in a patient care setting. Students will need career counseling in addition to progress reports. When counseling the employee, you must first confirm the individual's inherent worth as a person. You must take care to speak calmly, unemotionally, and respectfully. You should also make note of the things the employee has been doing correctly, before proceeding to the problem area. Determine what the obstacles to successful performance are (legitimate external factors, lack of training, low motivation, personal problems, etc.). Then, collaborate with the employee to develop a plan of corrective action with firm target dates. Document all interactions, keep track of progress or lack thereof, and finally take necessary action to have the employee relieved of duty, if no progress is made within the predetermined trial period.

k. **Preparing Evaluation Forms.** It is unethical to take the preparation of evaluation forms lightly. Inflated evaluations represent an irresponsible misuse of supervisory authority. Since promotions are based on evaluations, your words may cause a person with limited expertise and poor leadership skills to be placed in a position of authority. With the trend toward a "build down" in the Department of Defense, it is incumbent upon every supervisor to write honest and accurate evaluations that help advance only those with the skills and qualifications that warrant promotion.

4-9. SKILL LEVEL 4, 91P40 (E-7)

a. **Performing Duties of Preceding Skill Levels.** (As explained previously.)

b. **Inspecting and Supervising Medium-Sized Clinics.** While you might be asked to inspect a clinic at skill level 3, it is at skill level 4 that you will be charged with not only inspection but also supervision of a medium-sized clinic. The supervisory duties of skill level 4 are outlined below.

c. **Ensuring a Suitable Patient Care Environment**. All along, you have been seeing to it that your patients and co-workers have a safe, clean, orderly, comfortable, and emotionally secure environment. As an E-7, you will have to enforce policies and procedures to ensure that such an environment exists for the entire radiology department.

d. **Establishing Work Priorities and Distributing the Work Load**. (Self-explanatory.)

e. **Preparing Reports and Keeping Records**. In the lesson on medical records, the importance of records as a medical and legal documentation of health care decisions and actions was described. As an E-7, you will be responsible for ensuring that records are kept properly. You will have to prepare, review, and consolidate technical, administrative, and personnel reports.

f. **Coordinating Clinic Activities with Other Elements**. It will be your job to coordinate the activities of the x-ray department with those of other medical treatment facility elements. If the orthopedic department doesn't get along with the x-ray department, there will be many problems, even if you have the best staff, because an x-ray department does not function in a vacuum. To operate effectively, the x-ray department must function as one part of an integrated whole, in which an atmosphere of respectful cooperation prevails. If the OR department calls and says they will be having a case in the next 5 minutes, you cannot say, "That's too bad, we're short-handed."

g. **Providing Assistance**. For the most part, higher skill level duties are largely learned on the job by direct observation and practice. You will be asked to provide your input in the areas listed below.

(1) Personnel matters. (Typically, the 91P40 supervises a medium-sized x-ray clinic.)

(2) Supply economy procedures.

(3) Fiscal matters.

4-10. SKILL LEVEL 5, 91P50 (E-8)

a. **Performing the Duties of the Previous Skill Levels**. (As explained previously.)

b. **Supervising Large X-my Clinics or Facilities in U.S. Army Medical Center/Medical Department Activity (MEDCEN/MEDDAC) or in a General Hospital.** In addition to the sections found in a smaller facility, larger facilities will also include nuclear medicine, ultrasonography, magnetic resonance imaging, computed axial tomography, and therapy sections that must be supervised. Typically, the 91P50 supervises large x-ray activities in a MEDCEN/MEDDAC or general hospital.

Continue with Exercises, Section III

EXERCISES, LESSON 4, SECTION III

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. According to the duty by skill level guidelines*, at what skill level is a radiographer expected to perform portable examinations?

   a. SL 1.
   b. SL 2.
   c. SL 3.
   d. SL 4.

2. At what skill level ran a radiographer actually expect to conduct portable exams?

   a. SL 1.
   b. SL 2.
   c. SL 3.
   d. SL 4.

3. According to the duty by skill level guidelines, x-ray technologists will perform soft tissue exams, such as a mammogram at:

   a. SL 1.
   b. SL 2.
   c. SL 3.
   d. SL 4.

4. According to the guidelines, bone surveys used to evaluate the spread of cancerous tumors, arthritic joints, premature bone development, and provide documentation for suspected _____ are first done by radiographers at SL 1.

   a. Grand larceny.
   b. Child abuse.
   c. Rape.
   d. Homicide.

5. According to the guidelines, body sections, foreign body localizations, prenatal and pediatric x-ray exams, and various follow-up exams are first performed independently at:

   a. On-the-job training.
   b. SL 1.
   c. SL 2.
   d. SL 3.
   e. SL 4.

6. According to the guidelines, significant responsibility for the safety of clinics, personnel management, and supervision first occurs at:

   a. SL 1.
   b. SL 2.
   c. SL 3.
   d. SL 4.
   e. SL 5.

7. According to the guidelines, the inspection of x-ray clinics to ensure compliance with safety measures (turning off x-ray machines that emit too much radiation, using lead aprons with the collimator, having third-parties wear a lead apron when holding film) formally becomes a radiographer's responsibility at:

   a. SL 1.
   b. SL 2.
   c. SL 3.
   d. SL 4.
   e. SL 5.

8. Depending upon where you are assigned, you may actually have to inspect clinics as early as:

   a. SL 1.
   b. SL 2.
   c. SL 3.
   d. SL 4.
   e. SL 5.

9. According to the guidelines, internal coordination of clinic functions and external coordination with other elements of the treatment facility are first handled by x-ray technologists at:

a. SL 1.
b. SL 2.
c. SL 3.
d. SL 4.
e. SL 5.

10. According to the guidelines, at what skill level does the x-ray technologist supervise a medium-sized activity, inspect clinics, ensure a suitable patient-care environment, and establish work priorities and work load, etc.?

a. SL 1.
b. SL 2.
c. SL 3.
d. SL 4.
e. SL 5.

11. According to the guidelines, at what point will an x-ray technologist be expected to conduct platform instruction?

a. SL 1.
b. SL 2.
c. SL 3.
d. SL 4.

12. According to the guidelines, the radiographer assists with special exams rather than perform them independently at:

a. SL 1.
b. SL 2.
c. SL 3.
d. SL 4.

13. According to the guidelines, supervision of large x-ray clinics in a MEDCEN/MEDDAC or general hospital would occur at:

a. SL 1.
b. SL 2.
c. SL 3.
d. SL 4.
e. SL 5.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 4, SECTION III

1. b (para 4-7g)

2. a (para 4-7g and anecdote: "'Supertechs' Stay in the X-ray Department Where the Backlogs Exist ....")

3. a (para 4-6e(1))

4. b (para 4-6e(2))

5. c (paras 4-7e & f)

6. c (paras 4-8d - k)

7. d (para 4-9b)

8. c (para 4-8d)

9. d (para 4-9f)

10. d (para 4-9)

11. c (para 4-8g)

12. a (para 4-6h)

13. e (para 4-10)

Continue with Section IV

Section IV: SITUATIONS WHICH MAY GIVE RISE TO ACTIONS FOR LIABILITY FOR NEGLIGENCE

4-11. THE RADIOLOGIST

a. Increasingly, the radiologist has become an integral member of the health care team. With an ever more direct involvement in patient care has come an increasing likelihood of involvement in a malpractice suit as a defendant. Dramatic advances in technology have widened the horizons of radiology. These rapid advances, together with the rise in interventional procedures such as angioplasty (the repair of arteries using a balloon catheter), have contributed to the increased risk of being named as a defendant.

b. According to the St. Paul Insurance Companies, the largest medical malpractice carrier in the US, the radiology department ranked number six out of nine for hospital malpractice suits for the period 1983-1984. (Nursing and patient care areas ranked number one.)[10]

c. A survey of the malpractice suits filed against radiologists in Cook County, Illinois for a 62-month period (Jan 1975-Feb 1980) was conducted by Dr. Leonard Berlin, an Illinois radiologist. He found that of the 3,200 medical malpractice suits filed in that 5-year period, five hundred (or nearly 15 percent of all lawsuits) referred to radiologists or x-ray procedures. The radiology suits fell into five major areas. Missed diagnoses and complications thereof, accounted for 44 percent of the 500 radiology cases. The second highest category, failure to x-ray (with the primary care physician named as defendant, in most cases) represented 19 percent of the radiology cases. Radiation therapy injuries came next, accounting for 17 percent of the cases. Such injuries would be, primarily the radiologist's concern, but also the radiographer's responsibility, in some cases. For example, if a patient being treated for cancerous tumors incurred bums, it could be the radiologist's fault (if an excessive dosage had been prescribed). It could the be radiographer's fault if the machine had not been properly calibrated. It could also be the radiographer's fault if the error involved a failure to follow the dosage plan, for example, by setting the wrong dial. Slip-and-fall injuries, which accounted for 7 percent of the cases, involve injuries from slips and falls in or about the radiology department, being hit by equipment, or suffering rough handling by radiology personnel. Such mishaps would be primarily the radiographer's concern. And finally, miscellaneous cases accounted for 4 percent of the cases. Albert Bundy confirmed Dr. Berlin's results, finding a similar breakdown for radiology department malpractice suits in the research for his book, Radiology & the Law. Bundy found that most radiology malpractice lawsuits fell into one of the four nonmiscellaneous categories outlined by Dr. Berlin.[11]

d. The radiology department ranked number six out of nine for hospital malpractice suits for the period 1983-1984.[10]

St. Paul Insurance Companies.... Largest medical malpractice carrier in the US.

THE FOUR MAJOR CATEGORIES OF RADIOLOGY LAWSUITS (IN RANK ORDER)

1. Missed diagnoses and complications. (Largely, the radiologist's concern.)

2. Failure to x-ray. (Usually the primary physician's concern.)

3. Radiation therapy injuries. (Primarily the radiologist's concern, but also the 91P's.)

4. Slip-and-fall injuries-includes being struck by equipment, rough handling, etc. (Primarily the 91P's concern.)

4-12. ON RADIOLOGY PERSONNEL TO KEEP ABREAST IN A RAPIDLY CHANGING FIELD

a. **The Radiologist**. Since medical malpractice cases hinge on an appropriate standard of care from which the physician has allegedly imparted, it is critical for the radiologist, as a physician and a specialist, to conform to the standards of care for both groups. Many courts have established a broader standard of care for specialists, requiring that the specialist, in effect, adhere to a *national* standard in the field. To do this, the radiologist must keep abreast of advances in a rapidly developing field. Keeping everything current increases the likelihood of avoiding litigation, especially in missed diagnosis cases. Radiologists not fully trained or experienced in a particular subspecialty (ultrasonography, computed tomography, magnetic resonance imaging, nuclear medicine, interventional radiology) would do well to leave the procedure to a more experienced colleague.

b. **The X-ray Technologist**. It is equally important for x-ray technologists to keep up with new developments because both radiologist and radiographer are providing care in a rapidly changing field. If the radiographer is not fully trained or experienced in a subspecialty, his or her negligent actions could cause the radiologist and/or the hospital to be named in a lawsuit. Changes in state licensure requirements have supported the need for keeping abreast in a changing field. Radiographers are now required to show evidence of continuing education credits in order to maintain state licensure. (Twenty-five states have licensure laws. Military radiographers who also work in the civilian sector must meet these requirements.) A similar requirement is expected to take effect (in 1993) at the national level in order to maintain the national registry.

4-13. A CLOSER LOOK AT THE X-RAY TECHNOLOGIST

a. The radiologist relies on the skill and expertise of the radiographer to provide the baseline data needed to make an accurate interpretation of diagnostic tests. In addition, the radiologist relies on the radiographer to execute correct procedures for radiological intervention and treatment. It is the radiologist who determines the dosage for the treatment of a specific tumor. But, it is the radiographer who sets up the radiation unit for delivery of that dosage.

b. Besides taking radiographs, radiographers are now involved in a number of specialized imaging modalities such as computerized tomography, magnetic resonance imaging, ultrasonography, angiography and special procedures. X-ray technologists have to make decisions that affect the radiological examination. In the civilian setting, advanced degrees in nuclear medicine technology (the equivalent of the 91W MOB) and diagnostic medical sonography are offered in addition to a basic degree in radiologic technology. Initiatives are underway in the military to establish advanced training in the imaging modalities to keep up with the ever-increasing sophistication of the radiographer's role.

c. While military radiographers are not generally named as defendants in lawsuits, their actions can contribute to legal action against the government. As for civilian radiographers, they can be named, though not usually as sole defendants in a job-related incident. (The plaintiffs and their lawyers go after the "deep pockets," those with the malpractice insurance to cover hefty settlements.) Thus, if the incident occurs in a hospital, it is more likely that the hospital and radiologist would be named as defendants. In a private office, the radiologist and/or radiology group would probably be named. Even if the radiographer is not named, however, his or her actions can cause legal action to be brought against the radiologist, and/or the hospital under the *respondeat superior* doctrine. The radiologist may be liable for negligent acts of the radiographer, provided that an employer-employee relationship exists and the negligent act was committed within the scope of employment. According to Dr. Albert Bundy, direct liability of the radiographer is a potential reality, "since plaintiffs and attorneys are constantly searching for new frontiers of medical liability."[12]

AVERAGE LIABILITY PREMIUMS (1987)	
Radiology	$9,000
Physicians	$15,000
Anesthesia	$23,000
Surgery	$24,000
OB/GYN	$36,000
EVER-INCREASING AVERAGE VALUE OF A CLAIM	
1980	$18,000
1982	$23,000
1987	$35,000

Figure 4-3. This data, which is used in the 91P10 resident course, was obtained at a Radiology Symposium held at St. Philip's College in San Antonio, Texas, in September 1990. Although the figures are not as current as we would have liked, they still suggest the trend toward ever-increasing claims and premiums.

4-14. MISSED DIAGNOSES AND COMPLICATIONS

a. Radiologists are certainly not the only physicians who miss diagnoses. But a missed diagnosis is the most likely reason for which a radiologist may end up in court. In one study, the rate of disagreement among Harvard radiologists on the pathology of chest radiographs (Herman et al, 1975) confirmed the results of other previous studies in this regard.[13] The Harvard radiologists disagreed up to 56 percent of the time and had possible errors in 41 percent of their reports. Such disagreement can be found in other studies, as well.

b. In the area of ultrasound-related suits, a 1984 survey by Dr. Sanders[14] found the missed ectopic pregnancy as the most frequent reason for litigation in the missed diagnosis category. It also found several other nonobstetrical reasons for legal action, including missed appendiceal abscesses and missed gallstones. Finding lesions when, in fact, none existed, that is, carcinomas of the pancreas, gallstones, and IUDs, were another common cause for litigation.

c. When a radiologist misses a pathological finding on an imaging study, the critical question is whether the miss was through negligence or an error in judgment (a distinction that is sometimes difficult to make). A physician is likely to be found negligent if the injury resulted from a failure to follow accepted medical standards in taking the patient's medical history and in conducting standard diagnostic tests or a failure to use the most current medical knowledge and scientific methods in arriving at the diagnosis.

d. It is the radiologist's responsibility to require a proper radiological workup. If a study is incomplete or substandard, the radiographer should advise the radiologist. What determines the likelihood of showing liability of actionable negligence will be the injury suffered and how obvious the missed pathological finding was.

***SYGMAN vs KAHN* (N.Y., 1985): MISSED DIAGNOSIS**

A 49-year-old teacher was awarded $918,000 for a breast carcinoma that was not diagnosed in a timely manner. The patient went to her internist, the attending physician, for a breast lump. The internist referred her to a radiologist for a mammogram without performing a physician examination or writing up a detailed history. The mammogram was reported as negative. The patient later underwent a mastectomy for a cancer that had, by then, spread to the ribs, skull and apertures. The internist was liable for an act of omission, the failure to obtain a history. The radiologist should have made sure that the history was documented by the Internist prior to conducting the study.

***SHUFFLER vs BLUE RIDGE RADIOLOGY ASSOCIATES,* (N.C., 1985): MISSED DIAGNOSIS**

The patient was taken to an emergency room after falling from a truck. Spinal films were ordered, but the x-ray technologist could not obtain films showing the last cervical or first thoracic vertebra. In the radiologist's written report, no mention was made of the problems in taking the films. The report simply indicated no identifiable fractures of the patient's spine. In court, the radiologist testified that he had reported the difficulties of the examination to the physician. The physician denied that he had been so informed Twelve days after release, the plaintiff continued to suffer severe pain in the back and neck, with a "big knot" apparent in the affected area. Films, taken at the request of a neurosurgeon 22 days after the original films, revealed a fracture dislocation for which the patient was placed in traction and underwent surgery. The delay in detecting the fracture caused the patient 22 days of additional significant pain and complications. The ruling In favor of the patient held that the radiologist had established a standard of care when he stated the x-rays were incomplete and that he had breached that standard. It was also found that the radiologist's employer could be held liable since the radiologist had been acting as part of the group.

4-15. FAILURE TO X-RAY

The primary physician is usually named in cases involving a delay or failure to perform radiographic studies. A retired Army colonel and his wife received an out-of-court settlement of $285,000 for injury suffered because physicians at Walter Reed Army Medical Center and DeWitt Army Hospital refused to perform a biopsy on the woman's growing breast lump between 1984 and 1986. When a biopsy was finally conducted at Walter Reed Army Medical Center in 1986, the woman was found to have cancer. In 1988, she had to undergo a mastectomy.

KIMBALL vs SCORS (N.Y., 1977): FAILURE TO X-RAY

A patient went to his physician with complaints of blood in his stool, leg weakness, and digestive discomfort. He was referred to a radiologist. A liquid barium, upper gastrointestinal procedure was performed, but not a chest radiograph. Subsequently, the patient died from bronchogenic carcinoma of the lung. The court found that (allure of the radiologist to obtain a chest x-ray in a timely manner had deprived the deceased a substantial possibility of survival.

GRADEL vs INOUYE (Pa., 1980): FAILURE TO X-RAY

This case involved a 5-year-old boy with a fractured arm. Upon removal of the cast, the boy's mother noticed a lump at the site of the fracture, which kept steadily increasing in size. Without x-raying the arm again, the physician attributed the lump to callus formation. However later, amputation at the elbow was necessary to treat the lump, which proved to be cancerous. Had the physician ordered an x-ray when the lump was first discovered, the cancer would have been diagnosed earlier and the boy's arm could have been saved.

4-16. RADIATION THERAPY INJURIES

In the early 1900's, when radiology was a relatively new science, a number of the lawsuits involved bums and tissue damage suffered during diagnostic x-ray studies, which resulted from long and repeated exposures and an imprecise technology. Later, x-ray was used to treat various conditions, such as: acne, psoriasis, and lymph node inflammation or adenitis. Today, radiation therapy usually means cancer treatment. Cases involving the prescription of an excessive dosage are the radiologist's responsibility. Injuries resulting from the radiographer's failure to follow the dosage plan are the result of the radiographer’s error.

***SWEENEY vs ERVIN* (APP. D.C., 1913): RADIATION THERAPY INJURY**

The patient suffered a burn on the back following a number of visits to a physician. (It should be noted that not all of the early roentgenologists of the time were physicians.) The purpose of the visit was to diagnose a rib fracture suffered as a result of a railway accident. The defendant physician and a number of expert witnesses testified as to the good condition and use of the machine. They confirmed that the machine has been used in accordance with good practice. They added that it was not always possible to prevent such burns. The court still ruled in favor of the patient. The physician's defense that burns could not be prevented was weak in 1913, and would be even more indefensible now.

***GRUBB vs GROVER* (S.C., 1933). RADIATION THERAPY**

Initially, the court had ruled in favor of the defendant radiologist in a case involving burns suffered by the patient. But upon appeal to the Supreme Court, the higher court ruled that the radiologist had been negligent in leaving the room and going beyond hearing distance while the patient was receiving x-ray.

4-17. SLIP-AND-FALL INJURIES

Slip-and-fall injuries usually occur during the care and transport of the patient when being handled by an x-ray technologist. The court decisions that implicate the x-ray technologist also place ultimate responsibility on the radiologist and/or the hospital (under the doctrine of *respondeat superior*, "let the master answer"). For the most part, the radiographer is not named as a defendant at all, for the reasons stated earlier. But, it is generally the x-ray technologist's failure to take all necessary precautions in the care and transport of the patient that causes slip-and-fall injuries. Typical slip-and-fall injuries may involve an x-ray technologist, who fails to properly assist a patient onto the x-ray table, or an x-ray technologist who leaves a patient unattended on the table, or an x-ray technologist who fails to caution the patient about not bumping into equipment.

***HOSPITAL AUTHORITY OF HALL COUNTY vs ADAMS* (GA., 1964): SLIP-AND-FALL-LEAVING THE PATIENT UNATTENDED**

After taking a series of radiographs, the x-ray technologist left the patient, who was medicated and suffering from nausea, unattended on the x-ray table. Hearing groans as he reentered the room, the x-ray technologist assumed that the patient was in the bathroom vomiting. In fact, the patient was lying on the floor beside the x-ray table. The patient, experiencing a wave of nausea in the x-ray technologist's absence, had attempted to get off the table and walk to the bathroom by himself. But, because of the medication, he had lost his balance and suffered a fall and subsequent injury. The court ruled in the patient's favor. It held that the radiographer should have anticipated that a nauseous patient might try to use the bathroom and, that since the medication affected movement and coordination, the patient might suffer injury if allowed to move unassisted.

4-18. PREGNANCY

a. Before subjecting a female patient of child-bearing age to x-rays, the patient should be asked if she is or could be pregnant. Non-emergency studies should be postponed if there is any doubt, at all. In emergency situations, the risks versus the benefits should be evaluated. The literature indicates that doses as low as ten Rads administered at critical stages may cause embryonic abnormalities in rats and mice. While such doses do not seem to contribute to congenital malformation, intrauterine growth retardation, or fetal death in human embryos, they could cause mutagenic or carcinogenic effects.[15] Most diagnostic procedures performed on a potentially pregnant woman involve a dose of 0.3 to 1.0 rad. But the patient should be spared that risk, however minimal, and the anxiety over possible effects of exposure in the early stages of pregnancy when fetal development is most critical.

b. Pregnancy is one area that demonstrates the great importance of taking an accurate history. The x-ray technologist must make the appropriate inquiries *of* the patient. (From a legal standpoint, it is the primary physician who is implicated, not the radiologist, *if* a proper history is not taken.) The physician must find out about the patient's status with regard to pregnancy through proper testing and examination. The radiologist must ensure that if radiation is required, the study is monitored so that the fetus is exposed to the minimum dose possible.

***SALINETRO vs NYSTROM* (Fla., 1977): PREGNANCY**

In this case, neither the physician nor the x-ray technologist asked the patient *if* she were pregnant The *court, however, ruled* against the plaintiff because she herself did not know that the she was 4-6 *weeks pregnant* at the hire of the x-ray. The court ruled that even *if* the orthopedist's conduct fell below the standard because of his failure to ask the patient if she were pregnant, that error was not the cause of the injury. Had the patient been asked the crucial question, she would still have said she was not pregnant, and the x-ray would have been administered anyway.

4-19. NEWER IMAGING MODALITIES

a. **Ultrasonography.** While there is less litigation related to the newer imaging modalities as compared to the older techniques; in time, it is likely that the newer techniques will become just as common a basis of malpractice suits. Many of the ultrasound-related legal actions relate to the physician failing to perform a sonogram. The majority of the cases involving ultrasonography involve obstetrical sonography. But, radiologists who don't perform obstetrical sonography may still become involved in a suit involving the missed ectopic pregnancy, the most common cause for litigation in Dr. Sander's missed diagnosis category.[16] Other common nonobstetrical reasons for legal action include missed appendiceal abscesses and missed gallstones. A radiologist may also end up in court for finding lesions that don't exist, such as a carcinoma of the pancreas, gallstones, and intrauterine devices (IUDs). Therapeutic sonograms for muscular problems have also figured in the reported cases. Radiologists and sonographers should be careful not to perform an interventional procedure that is of questionable value, as they will be held to a *higher* standard of care than the primary physician, as the residing specialist in the case.

b. **Computed Tomography.** Among the newer modalities, the computed axial tomographic (CAT) scan figures in malpractice cases because of the frequent need for intravenous contrast and the occasional need to sedate the patient. In addition, CAT scans are often used as evidence, especially in worker's compensation cases in which a back injury is alleged.

***WATERFORD vs HALLOWAY (Ill.* App., 1986): FAILURE TO USE A SONOGRAM**

The plaintiff brought suit against her gynecologist for failing to use a sonogram to diagnose and treat an abscess that she developed after a hysterectomy. The defendant physician opted to conduct a pelvic examination rather than use a sonogram. Expert medical testimony revealed the sonogram to be an acceptable alternative to the pelvic examination as a diagnostic tool in a case such as this. Initially and on appeal, the court ruled In favor of the defendant gynecologist.

COMPUTERIZED AXIAL TOMOGRAPHY SCAN CONTRAST REACTION CASE SETTLED OUT OF COURT

The family of a Florida man who had been comatose for 3 years, sued for negligence allegedly arising out of a contrast reaction during a CAT scan that caused the man to go into shock and then a coma. The plaintiffs maintained that the hospital staff had been negligent in failing to react quickly enough to prevent permanent harm. In the $7.3 million settlement, the hospital paid $4 million, the two radiologists paid $20 million, and the pulmonary specialist paid $500,000.

4-20. OVERSTEPPING ONE'S BOUNDS

a. The x-ray technologist should take pains not to overstep the bounds of the practice. A radiographer should not, for example, perform a procedure that has not been ordered by the physician. For example, a radiologist orders an x-ray of the knee. The radiographer does the film as requested, but detects an abnormality and, thus, decides to do a view of the entire leg, reasoning that additional views of an adjacent area would be helpful. The radiographer should, in such a case, call the requesting physician to see if the additional study is, in fact, needed. Taking it upon oneself to do extra x-rays can lead to additional problems. If, for example, the patient knew that the physician had only ordered an x-ray of the knee, he or she might become upset when the x-ray technologist touched the entire leg. The patient could quite conceivably interpret this as an untoward advance, which could precipitate a complaint for inappropriate behavior or a lawsuit for needless exposure to radiation.

b. Since radiologists may be held accountable for the negligent acts of x-ray technologists occurring within the scope of employment, the radiologist must be conscientious about defining the duties of each particular x-ray technologist. He or she should also provide for proper supervision. Improper delegation of duties or inadequate supervision can lead to litigation. The x-ray technologist, for his or her part, should also be aware of the potential risks involved if such irregularities do exist. (See next page for anecdote, 'Toddler Dies...")

4-21. FALLING SHORT OF THE SCOPE OF ONE'S DUTIES

As important as staying within the parameters of your scope of duty is not falling short of what is expected. To meet the standard of care established for your profession, you must perform every aspect of your job to the best of your ability, with alertness to the particular needs of the patient, and a sense of responsibility and commitment to the task at hand. Falling short can have dire consequences. A breach of the standard of care is one element of proving actionable negligence.

TODDLER DIES OF SEDATION OVERDOSE BECAUSE X-RAY TECHNOLOGISTS WERE WORKING OUTSIDE THE SCOPE OF PRACTICE

Following *is* a tragic incident that highlights both the importance of having patience with young patients and the criticality of working within the scope of practice, i. e., doing only those procedures and examinations for which you have been trained.

Raymond and Mary Portlock filed suit against the Duncanville Diagnostic Center, a radiologist and two radiographers for the negligent death of their 4 1/2-year-old, who died as a result of acute chloral hydrate Intoxication. Brought to the clinic for a routine cystourethrogram and an intravenous pyelogram, little Erica was having difficulty settling down for the exam. So, the two x-ray technologists Involved inquired if the radiologist could give Erica something to calm her nerves. The physician told the x-ray technologists to give Erica chloral hydrate, which, as would be expected, made her unconscious. After the examination was completed, the x-ray technologists sent the still unconscious Erica and her parent's home. Erica never regained consciousness. She died later that day.

The x-ray technologists allegedly failed to ascertain the proper dosage from the physician, they failed to measure the medication, and failed to document the administration of the narcotics. But, by the very act of administering narcotics, the x-ray technologists were performing outside the scope of practice. Donna Hardin, program administrator of the Texas Department of Health's Medical Radiologic Technology program, indicated that no reprisals could be taken against the x-ray technologists because the administration of narcotics does not tail under the jurisdiction of that agency. She went on to say, "Under the Medical Practice Act, [x-ray technologists] are permitted to take orders from a physician, even if the orders don't fall under their scope of practice."[18] Thus, as the regulation now stands, x-ray technologists may perform duties for which they have no training, e.g., administering narcotics, if the physician so delegates.

As a result of this loophole in the regulation, the two defendant x-ray technologists are still licensed and practicing in Texas. Further, their names are likely to be deleted from the suit. Even If they had insurance it wouldn't cover the case because they had been working outside the scope of practice.

As a result of this case, the rules of professional conduct are being revised so that the radiographer's liability will encompass not only "radiologic" but "medical" procedures as well, As part of the defendant radiologist's out-of-court settlement, he has been ordered to write a paper outlining the procedures and treatments that a physician can legitimately delegate to an x-ray technologist. Says Hardin, "I hope the paper will help encourage technologists to refuse orders if they are not trained to carry them out" [19]

4-22. AN OUNCE OF PREVENTION

a. **Reduce Unwanted Litigation**. In his book Radiology) and the Law, Dr. Bundy suggests 15 practical steps that can help radiologists to reduce the likelihood of unwanted litigation.[17] These guidelines also have some applicability to the radiographer. Some of these steps are common sense measures that have been covered elsewhere in this text, but they bear repeating in that they provide a helpful recap of this section.

b. **Talk to the Patient**. By letting the patient know who you are, putting him or her at ease, and answering questions truthfully you are less likely to turn a patient into a plaintiff. For the technologist, this may mean telling the patient, "Im sorry, I can't answer that question. But, Dr. Jones will be right with you to go over everything with you shortly."

c. **Obtain the Appropriate History.** Missed diagnosis, slip-and-fall, or contrast reaction cases may be reduced if the x-ray technologist and the radiologist know the relevant information about the patient's history.

d. **Avoid Performing Studies for Which You Are** Not Properly Trained. If you, as a radiographer, lack the necessary background in subspecialties such as ultrasonography, interventional radiology, or magnetic resonance imaging, you should alert your supervisor to this deficiency so that a decision can be made about referring the patient elsewhere.

e. **Avoid Performing Unnecessary Studies**. (Self-explanatory.)

f. **Know You Referring Physicians**. The radiologist can facilitate proper diagnosis by suggesting the appropriate radiological workup of a problem.

g. **Submit Reports on Time**. The radiologist should be responsible for phoning in any finding that requires prompt attention. In your report, document that the matter was discussed with the appropriate physician. (Refer back to *Shufer vs Blue Ridge Radiology Associates*.

h. **Read Your Reports Before You Sign Them**. Miscommunication or misinformation resulting from a typographical error is avoidable if the radiologist takes the time to re-read his or her report before signing it.

i. **Be Complete**. Be sure to document incomplete studies and the reason it was incomplete. Ultimately, it is the radiologist who will be held accountable for incomplete studies. But, the radiographer has a responsibility to advise the radiologist about incomplete or substandard studies. (Again, see Shuffler vs Blue Ridge *Radiology* Associates.

j. **Document Your Findings Credibly**. The radiologist's documentation should be of good quality, even if it entails repeating some of the study. Ultrasound protocols should be strictly adhered to. Pathology seen in fluoroscopy should be documented so others can see what you mean.

k. **Take Necessary Precautions to Prevent Patient Falls**. Simple measures taken by the x-ray technologist, like making sure that rails are up and patients are watched while they are in the radiology department, are crucial. An especially vulnerable time is when the radiographer is developing films and the patient is unattended. Remember that slip-and-fall cases constitute the largest category of patient suits. And, it doesn't matter how competent a radiologist or an x-ray technologist you are. Vigilant enforcement of simple precautionary measures is what counts as far as reducing the number of slip-and-fall cases.

l. **Keep Abreast of New Developments in Your Field**. Pay particular attention to the subspecialties you practice. Read a medicolegal journal regularly to become aware of the legal trends in your area of practice. (As stated earlier, a failure to use the most current medical knowledge and scientific methods can constitute a deviation from the accepted standard of care and, thus, a basis for proving one of the elements of actionable negligence.)

m**. Get a Second Opinion When Needed**. This is especially important for the radiologist to do when a major medical decision is being based on radiological findings that are subject to a variable interpretation.

n. **Supervise Residents Properly**. (This, of course, refers to physicians.)

o**. Supervise X-ray Technologists**. X-ray technologists should be encouraged to take on responsibility but discouraged from performing the radiologist's duties. (Refer back to para 4-20 for an example.)

p. **Guidelines Encouraged**. Encourage medical societies to establish guidelines for performance and interpretation of various examinations. Guidelines that are specific rather than general can be of great value in determining the *standard* of care. And, in negligence cases, identifying the standard of care is a critical prerequisite to determining whether or not a deviation from the standard has occurred.

Continue with Exercises, Section IV

EXERCISES, LESSON 4, SECTION IV

It is recommended that you work the following exercises before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the **ONE** response that **BEST** completes the statement or **BEST** answers the question.

1. Which category of radiology department mishaps is primarily a result of the x-ray technologist's failure to use good judgment and follow correct procedure?

   a. Missed diagnosis and complications.
   b. Failure to x-ray.
   c. Radiation therapy injuries.
   d. Slip-and-fall injuries.

2. Which category of radiology department mishaps is primarily the radiologist's responsibility but may also be, in some instances, the x-ray technologist's?

   a. Missed diagnoses and complications.
   b. Failure to x-ray.
   c. Radiation therapy injuries.
   d. Slip-and-fall injuries.

3. Most medical malpractice cases hinge upon:

   a. The gravity of the injury incurred by the defendant.
   b. The reputation of the hospital and the physician.
   c. The media-worthiness of the lawsuit and the amount of publicity it receives.
   d. An appropriate standard of care from which the provider has allegedly departed.

4. As specialists, radiologists are expected to conform to:

   a. Only the local standard of care.
   b. The same standard of care as for any other physician.
   c. A broader standard of care for the field, encompassing the national standard.
   d. Only the standard set by the state.

5. If a radiologist or an x-ray technologist fails to keep abreast of the most current knowledge and scientific methods, the risk of deviating from the accepted standard of practice by using inferior or antiquated procedures is:

   a. Increased.
   b. Decreased.
   c. Unaffected.
   d. Unknown.

6. A patient receiving radiation therapy for a cancerous tumor suffers bums due to an excessive dosage. In the resulting lawsuit, the _____ are most likely to be named as defendants.

   a. X-ray technologist and radiologist.
   b. Radiologist and the hospital.
   c. Primary physician and radiologist.
   d. Primary physician and x-ray technologist.

7. A patient suffers bums during treatment as a result of an improperly calibrated therapy unit. Most *likely* to be *named* in the resulting lawsuit are the:

   a. Radiologist and the hospital.
   b. X-ray technologist and the radiologist.
   c. Primary physician and the radiologist.
   d. Primary physician and the x-ray technologist.

8. Which is the most likely reason for which a radiologist may end up as a defendant in a malpractice suit?

   a. Radiation therapy injuries.
   b. Failure to x-ray.
   c. Missed diagnosis and subsequent complications.
   d. Slip-and-fall injuries.

9. The most common cause for litigation in the missed diagnosis category is:

   a. Missed tumors in the pelvic region.
   b. Missed hairline fractures.
   c. Missed kidney stones.
   d. Missed ectopic pregnancies during ultrasonography.

10. Which of the following practices will help the x-ray technologist to reduce the likelihood of causing injury to the patient through negligence?

a. Taking an accurate history.
b. Taking additional studies besides those ordered by the physician.
c. Discussing x-ray results with the patient.
d. Performing a study for which one is not properly trained.

11. CAT scans have figured in malpractice cases because of negligent injuries arising out of the need for intravenous contrast and the occasional need to:

a. Sedate the patient.
b. Restrain the patient.
c. Confine the patient inside the CAT unit.
d. Locate the palpation point.

12. The x-ray technologist can contribute to a reduced number of patient injuries and malpractice suits by:

a. Relying on the patient's common sense.
b. Helping to write the radiologist's report.
c. Taking the necessary precautions to prevent patient falls.
d. Writing good guidelines for interpretation of various examinations.

13. To avoid harm to the patient and possible ethical and legal problems for the health care team and hospital, radiographers should avoid performing tasks:

a. Learned through OJT.
b. Outside the scope of practice.
c. For which they have been trained.
d. Ordered by the radiologist.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 4, SECTION IV

1. d (para 4-11 & and fig 4-1)
2. c (para 4-11 & fig 4-1)
3. d (para 4-12a)
4. c (para 4-12a)
5. a (para 4-12a)
6. b (para 4-11)
7. a (para 4-11)
8. c (para 4-14)
9. d (para 4-19)
10. a (para 4-18)
11. c (para 4-19a)
12. c (para 4-22k)
13. b (para 4-20 and anecdote, "Toddler Dies..:")

NOTES

1. Rick Carlton, M.S., R.T. "Continuing Education is the Answer," RT Image (Letter to the Editor), Vol. IV, No. 44, pp 18-19, November 4, 1991.

2. Linda Cox, BS, RT, "A Vote for Continuing Education, "RT Image (Letter to the Editor), Vol. IV, No. 44, pp 18-19, November 4, 1991.

3. Albert L. Bundy, Radiology and the Law, Aspen Publishers Inc., 1988, pxi.

4. Bruce J. Hillman, M.D., et al, "Frequency and Costs of Diagnostic Imaging in Office Practice-A Comparison of Self-Referring and Radiologist-Referring Physicians, "The New England Journal of Medicine, Vol. 323, No. 23, pp 1604-1608, December 6, 1990.

5. Ibid.

6. Carol Mehne, "ALARA at Work," RT Image, Vol.4,No.37, p 1-6, Sep 16, 1991.

7. Larisa A. Kuntz, "What is Ethical?" RT Image, Vol. IV, No. 44, pp 20-21, Nov 4, 1991.

8. Ibid.

9. Ibid.

10. Bundy, p 25.

11. Ibid., p 26.

12. Ibid., p 183.

13. Ibid., pp 83-84.

14. Ibid., p 143.

15. Ibid., p 35.

16. Ibid., p 143.

17. Ibid., pp 195-196.

18. A. Loudin, "Routine Exam Leads to Death," RT Image, Vol. IV, No. 30, p 60, September 3, 1991.

19. Ibid.

End of Lesson 4

APPENDIX A

CODE OF ETHICS FOR X-RAY TECHNOLOGISTS

A code of ethics serves as a guide by which professionals may evaluate their professional conduct as it relates to patients, colleagues, and other members of the allied professions and health care consumers. The code of ethics is not law, but it is intended to assist technologists in maintaining a high level of ethical conduct.

Principle 1. The Radiologic Technologist conducts himself/herself in a professional manner, responds to patient needs, and supports colleagues and associates in providing quality patient care.

Principle 2. The Radiologic Technologist acts to advance the principal objective of the profession to provide services to humanity with full respect for the dignity of mankind.

Principle 3. The Radiologic Technologist delivers patient care and services unrestricted by the concerns of personal attributes or the nature of the disease or illness, and without discrimination regardless of sex, race, creed, religion, or socioeconomic status.

Principle 4. The Radiologic Technologist practices technology founded upon theoretical knowledge and concepts, utilizes equipment and accessories consistent with the purposes for which it has been designed, and employs procedures and techniques appropriately.

Principle 5. The Radiologic Technologist assesses situations; exercises care, discretion, and judgment; assumes responsibility for professional decisions; and acts in the best interest of the patient.

Principle 6. The Radiologic Technologist acts as an agent through observation and communication to obtain pertinent information from the physician to aid in the diagnosis and treatment management of the patient, and recognizes that interpretation and diagnosis are outside the scope of practice for the profession.

Principle 7. The Radiologic Technologist utilizes equipment and accessories, employs techniques and procedures, performs services in accordance with an accepted standard of practice, and demonstrates expertise in limiting the radiation exposure to the patient, self, and other members of the health care team.

Principle 8. The Radiologic Technologist practices ethical conduct appropriate to the profession, and protects the patient's right to quality, radiologic technology care.

End of Appendix A

APPENDIX B

A MODEL OF THE PATIENT'S BILL OF RIGHTS

1. The patient has a legal **right** to informed participation in all decisions involving his or her health care program.

2. We recognize the **right** of all potential patients to know what research and experimental protocols are being used in our facility and what alternatives are available in the community.

3. The patient has a legal **right** to privacy respecting the source of payment for treatment and care. The right includes access to the highest degree of care without regard to the source of payment for that treatment and care.

4. We recognize the **right** of a potential patient to complete and accurate information concerning medical care and procedures.

5. The patient has a legal **right** to prompt attention, especially in an emergency situation.

6. The patient has a legal **right** to a clear, concise explanation of all proposed procedures in layman's terms, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. He or she will not be subjected to any procedure without his or her voluntary, competent, and understanding consent. The specifics of such consent shall be set out in a written consent form signed by the patient.

7. The patient has a legal **right** to a clear, complete, and accurate evaluation of his or her condition and prognosis without treatment before he or she is asked to consent to any test or procedure.

8. We recognize the **right** of the patient to know the identity and professional status of all those providing service. All personnel have been instructed to introduce themselves, state their status, and explain their role in the health care of the patient. Part of this right is the right to know the physician responsible for his/her care.

9. We recognize the **right** of any patient who does not speak English to have access to an interpreter.

10. The patient has a legal **right** to all the information contained in his or her medical record while in the health care facility and to examine the record upon request.

11. We recognize the **right** of a patient to discuss his or her condition with a consultant-specialist at his or her own request and his or her own expense.

12. The patient has a legal **right** not to have any test or procedure designed for educational purposes, rather than for his or her direct personal benefit, performed on him or her.

13. The patient has a legal **right** to refuse any particular drug, test procedure, or treatment.

14. The patient has a legal **right** to both personal and informational privacy with respect to: the hospital staff, other doctors, residents, interns and medical students, researchers, nurses, other hospital personnel, and other patients.

15. We recognize the patient's **right** of access to people outside the health care facility by means of visitors and telephone. Parents may stay with children and relatives with terminally ill patients 24 hours a day.

16. The patient has a legal **right** to leave the health care facility, regardless of physical condition or financial status, although he or she may be requested to sign a release stating that he or she is leaving against the medical judgment of his or her doctor or the hospital.

17. No patient may transfer to another facility unless: he or she has received a complete explanation of the desirability and need for the transfer, the other facility has accepted the patient for transfer, and the patient has agreed to transfer. If the patient does not agree to transfer, the patient has the **right** to a consultant's opinion on the desirability of transfer.

18. The patient has the **right** to be notified of discharge at least 1 day before it is accomplished, to demand a consultation by an expert on the desirability of discharge, and to have a person of the patient's choice notified.

19. The patient has the **right**, regardless of source of payment, to examine and receive an itemized and detailed explanation of his or her total bill.

20. The patient has the **right** to competent counseling to help him or her obtain financial assistance from public or private sources.

21. The patient has the **right** to a timely prior notice of the termination of his or her eligibility for reimbursement for the expense of his/her care by any third-party payer.

22. The patient has the **right**, at the termination of his or her stay, to a complete copy of the information in his or her medical record.

23. The patient has the **right** to have 24-hour-a-day access to a patient's rights advocate, who may act on behalf of the patient to assert or protect the rights set out in this document.

End of Appendix B

APPENDIX C

GLOSSARY

NOTE: The symbol ✱ denotes a term occurring in MD0066, Health Care Ethics I.

A

✱ **actionable negligence:** negligence for which legal responsibility (liability) can be assessed (para 4-1 a).

✱ **actor (defendant):** the party against whom damages are sought for injury in a tort suit (para 4-2a).

✱ **assault:** a threatening approach that puts a person in fear of battery, unauthorized touching (para 4-3b(1)).

✱ **attitude:** a grouping of beliefs around a specific object or situation; how one *feels* about something (para 2-2d).

B

✱ **battery:** intentional touching of another person without authorization (para 4-3b(2)).

✱ **belief:** the *conviction* that something is true (para 2-2c).

✱ **beneficence:** the concept that the role of the health care provider is to care for the patient, to do good (para 1-13g, anecdote).

✱ **biomedical ethics:** a philosophical study of what is right and wrong in the modern biological sciences, medicine, health care, and medical research (para 1-5a).

✱ **brain death:** the irreversible cessation of circulatory and respiratory functions or of all functions of the entire brain, including the brain stem (para 2-9d).

✱ **breach of duty:** failure to provide a specific duty that is owed to the patient (para 4-7b).

C

✱ **claimant (plaintiff):** the alleged injured party who seeks damages in a tort suit (para 4-2a).

✱ **clinical ethics:** a type of ethics that involves identification, analysis, and resolution of moral problems encountered at the bedside (para 1-5a).

✱ **common law:** a body of laws originating from Federal, state, and local court decisions (para 3-5a).

✱ **compensatory damages:** payment designed to make the injured party "whole" to the extent that money can do so (para 4-2b).

competent (for consent purposes): having the mental capacity to understand information, deliberate according to values, weigh the consequences of one's own decisions, and communicate one's wishes; a legal determination (para 1-23b).

confidentiality: the ethical responsibility of health care providers to maintain the secrets of their patients, communicated to them or learned through observation, examination, or conversation, and not to communicate same except to those with an official need to know (para 3-8).

consent: the free *(uncoerced*) authorization of the patient to make his or her own decisions as to whether or not, and how to receive competent medical care (para 1-2).

D

* **damages:** payment (compensation) for injury in a tort suit (para 4-2b).

* **decisions and rules:** mandates and decisions from Federal and state administrative agencies, e.g., the Environmental Protection Agency (EPA), the Food and Drug Administration (FDA), the Internal Revenue Service (IRS) (para 3-4a).

* **defamation:** injury to another person's reputation, either spoken (slander) or in writing (libel) (para 4-3c).

* **defendant:** See "actor."

* **Do Not Resuscitate (DNR) order:** a written order to suspend an otherwise automatic initiation of cardiopulmonary resuscitation (CPR) (para 2-8a).

E

emancipated minor: a minor who has assumed the life-style and responsibilities of adult status and is not supported by either parent (para 1-26c).

ethical integrity of the health care profession: the medical profession's right to act affirmatively to save lives without fear of civil liability (para 2-17).

* **ethics:** a disciplined study of morality (what is right and wrong). It attempts to sort out the confusion created by the conflicting sources of morality (para 1-4).

express consent: consent given by direct communication, either orally or in writing (pare 1-7).

extension doctrine: the doctrine that allows the physician the prerogative to extend care beyond the scope of express consent in an emergency (para 1-6d).

F

* **false imprisonment:** unlawful restraint or detention of a person (para 4-3d).

G

H

✱ **Hawthorne effect:** a temporary positive effect resulting from any changes in environment or conditions (pare 1-1f).

I

implied consent: approval *inferred* from the patient's conduct; or voluntary submission with *apparent* knowledge of the nature of the procedure; or *presumed* consent in a life-threatening emergency (para 1-6).

incompetent (for consent purposes): lacking the mental capacity to make rational decisions or to conduct one's personal affairs; a legal determination (para 1-24).

informed consent: the free *(uncoerced)* authorization of a procedure that is given by a competent individual, having *sufficient information* (para 1-2b).

✱ **injury:** a physical, financial, or emotional act, or some other invasion of the plaintiff's rights and privileges (para 4-8a).

✱ **instrumental value:** a decision to choose one mode of conduct, e.g., honesty, cooperation, self-control, over another (para 2-2b).

✱ **intentional tort:** a wrongful act that arises from the intent (not necessarily hostile) to bring about a result that will invade the interests of another in a legally unsanctioned way (para 4-3a).

✱ **invasion of privacy:** interference with the right of a person "to be let alone" (para 4-3e(1)).

irreversible terminal illness: a progressive disease or illness known to terminate in death, and for which additional therapy offers no reasonable expectation of remission (para 2-8b).

J

K

L

✱ **liable:** legally responsible (para 4-4b).

life-sustaining treatment: any medical procedure or intervention which serves only to artificially prolong the dying of a patient, diagnosed and certified by at least two physicians as afflicted with a terminal condition or as being in a persistent or chronic vegetative state (para 2-9b).

M

❋ **malpractice:** professional negligence; failure to render proper services through reprehensible ignorance, negligence, or criminal intent, especially with resultant injury or loss (para 4-4b).

materiality (material risk) standard of disclosure: the standard of disclosure whereby the physician's duty to disclose information material to the decision is determined by the informational needs of a hypothetical *objective "reasonable patient,"* not by professional practice (para 1-14c).

medical record: a document that outlines patient evaluation, findings, diagnosis, and/or treatment (para 3-1).

mental capacity: the ability to make decisions and weigh alternatives; a clinical determination made by the physician (para 1-24d).

❋ **morality:** conformity to the rules of right conduct (para 1-4).

❋ **moral dilemma:** a no-win situation in which the choice is between conflicting moral principles of equal importance (para 2-7).

N

❋ **negligence:** conduct which falls below a standard established by the law for the protection of others against unreasonable risk of harm; failure to exercise such care as would be expected of a reasonable person (para 4-4a).

❋ **normative ethics:** a type of ethics that formulates ethical theories and specifies behaviors that support ethical standards (para 1-5d).

O

P

paternalism: a practice of treating people in an authoritarian manner, especially by taking care of their needs without giving them any responsibility for health care decisions (para 1-13g, anecdote).

persistent vegetative state: a chronic state of diminished consciousness resulting from severe generalized brain injury, in which there is no reasonable possibility of improvement to a cognitive (perceiving and knowing) state (para 2-8b).

❋ **placebo effect:** a positive therapeutic effect resulting from an inert medication, preparation, or intervention given for its psychological influence, or as a control in an experiment (para 1-1f).

❋ **plaintiff:** See "claimant.

privacy: the right "to be let alone," to be free from unwarranted publicity, to live without having one's name, picture, or private affairs made public or published against one's will (para 3-6).

❋ **private law:** a body of laws governing the relationship between private individuals and organizations (para 3-7b).

privileged (confidential) communication: communication between parties in a confidential relationship (physician-patient, lawyer-client, clergyman-layperson, husband-wife). The confidence is transmitted under circumstances implying it shall forever remain a secret (para 3-10a).

❋ **professional ethics:** a set of standards of professional conduct set down in codes (para 1-5b).

❋ **professional code of ethics:** a statement of role morality for a given profession, as expressed by member of that profession, rather than external bodies such as governmental agencies (para 1-5b).

professional practice standard of disclosure: a standard of disclosure that requires the physician to disclose what any reasonable *health care* provider would communicate in the same or a similar circumstance (para 1-14b).

❋ **proximate cause (causation):** the process of establishing the causal link between breach of duty and injury (para 4-9).

❋ **public law:** a body of laws governing the relationship between private individuals and government (or governmental agencies) in order to protect society as a whole (para 3-7c).

❋ **punitive damages:** compensation set at a high level in order to punish the actor and serve as an example to deter others (para 4-2b).

Q

R

reasonable person (materiality) standard of disclosure: See "materiality (material risk) standard of disclosure."

❋ **reasonable person standard of duty:** a measurement of the actors conduct against what a reasonably *prudent person* would have done under the same or a similar circumstance (para 4-7a).

❋ **res ipsa loquitur:** the legal doctrine in which all four elements of actionable negligence need not be proven; literal meaning: "the thing speaks for itself" (para 5-1a).

❋ **respondeat superior:** the legal doctrine that holds the employer liable for negligent torts committed by the employee within the scope of the employee's duties or employment. Literal meaning is "let the master answer." (The employer is not generally liable for the intentional torts of its employees) (para 5-3a).

S

✱ **statutory law:** a body of written laws originating in Federal, state, and local legislatures (para 3-3a).

subjective test of the reasonable patient standard of disclosure: the standard whereby the physician's duty to disclose information material to the decision is determined by the informational needs of the *individual patient* (para 1-14c(2)).

T

✱ **terminal value:** a value based on a decision to choose one end-state of existence in favor of another, e.g., quality of life versus sanctity of life (para 2-2b).

therapeutic privilege: the physician's prerogative to withhold information if he or she reasonably believes that the patient's mental or physical well-being would suffer as a result of learning the information. (Consent must still be obtained, usually from a relative) (para 1-18)).

✱ **tort:** a civil wrongdoing or injury, other than contractual, which gives rise to an action for damages to compensate the injured party (paras 3-9c and 4-2a).

U

V

✱ **value:** a goal or an ideal upon which we base decisions affecting our lives (para 1-1c).

W

X

Y

Z

End of Appendix C